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Topic 1: Public Health management at District level: Concepts and Values

A hand out from the project on "Integrated management of public health programmes at district level"

This project was developed by incorporating ideas, suggestions and contribution from an interactive participatory process of dialogue and consultation involving public health and multidisciplinary resource network drawn primarily from mainstream institutions and the civil society network in India.

A draft manual evolved covering concepts and values Roles, Skills and Challenges and an Integrated Paradigm for the Public Health Management at District leve. It also elaboarates on, making a district diagnosis; organizing a health management information system; evolving a district plan; organizing an epidemiological surveillance system; responding to an epidemic and managing an outbreak; managing health programmes; managing human resources; organizing materials management; monitoring and evaluation; leading and building a health team; promoting, communicating and advocating for health; promoting and sustaining community partnerships; and building and sustaining partnerships with the educational sector; civil society, private sector and promoting an inter-sectoral collaboration.

Developed by
Centre for Public Health and Equity, and its associates, for the Society for Community Health Awareness Research and Action, Bangalore.

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Preface

This document is intended to serve as an evolving conceptual **framework for district level public health managers** in the health systems of the South East Asian countries. These managers, their knowledge, skills, attitudes, and openness to new challenges and new paradigms will remain one of the key determinants of the success of countries in reaching the **"Health For All"(HFA) vision** and the ***Millennium Development Goals(MDG's)***.

This document is a practical do it yourself workbook that draws upon some of the wealth of experience and resources in the past and present and tries to help district level managers address the complexities of today's challenging global, national and local health situation and the emergence of new challenges and reemergence of older ones.

Readers are adviced not to treat this document as a comprehensive manual but as **an evolving compilation of concepts in public health management**. This conceptual framework contains suggestions to tackle some of the problems, that the district level public health managers meet in their daily life as they lead, assess, respond, evaluate and learn from numerous health systems challenges. Where possible and feasible it directs the readers to other resources that will provide them additional perspective and details.

The authors/ facilitator have worked in the community and have had the experience in supporting capacity building for public health/ community health in the main stream and civil society linked alternatives sector. They have also tried to draw upon the experience and the field-oriented perspectives of a network of public health capacity builders and trainers from the mainstream public health institutions and civil society training centers.

This is ***a work in progress.*** The conceptual framework will, we expect, evolve into a guidebook that gets used and adapted by district level public health managers, trainers and supervisors of district level public health programmes. The document is expected to continue to eveolve with the feedback from users making it more relevant, responsive, context specific and focused.

We see this document as the beginning of a new journey - ***a journey of strengthening district level public health management.***

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1. Public Health Management at District level: Concepts and Values

Introduction: The person taking up a role and responcibility at district level as a part of pubic health practiece has complex challenge posed by health systems which s/he has to address in today's reality. Much of the task may be 'putting the national primaryhealth care policy into action'[1].

This evolving manual believes that s/he can meet this reality if they understand the basic values, principles and goals of health systems committed to reaching **Health For All**. Some of them are old values and old definitions, which are being reiterated and renewed. Some are newer ideas and paradigms that have emerged as responses to continuing health systems challenges.

The concepts and values included in this document are;

- ***Public Health***
- ***District Health systems***
- ***Health For All***
- ***Primary Health care***
- ***Equity***
- ***Gender***
- ***Solidarity***
- ***Right to Health***

Key Concepts

We request you to spend a little time reflecting on these concepts and values. How can you make the health systems under your management be responsive/ sensitive to these values and goals?

a) Public Health

Public Health has been an evolving discipline through which major health gains for population around the world. Unfortunately in the late 1980's and most of the 1990's this discipline was grossly underfunded and distorted by the new economic policies that weakened public health systems, and made them in efficient or in effective. Since the Calcutta Declaration in 2000[2], public health has been revalued and reenergized in the region by a new public health initiative to strengthen this discipline at all levels of the health system. This manual is one such effort. Public Health has been defined as follows;

> "**Pubiic health** is one of the efforts organised by society to protect, promote, and restore the people's health. It is the combination of sciences, skills, and beliefs that are directed to the maintenance and improvement of the health of all the

people through collective or social actions. The programs, services, and institutions involved emphasise the prevention of the disease and the health needs of the population as a whole. Public health activities change with changing technology and social values, but the goals remain the same: to reduce the amount of disease, premature death, and disease- produced discomfort and disability in the population. Public health is thus a social institution, a discipline and a practice."[3]

"**Public Health** is the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society"[4].

"**Public health** is a social and political concept aimed at the improving health, prolonging life and improving the *quality of life* among whole populations through *health promotion, disease prevention* and other forms of health intervention. A distinction has been made in the *health promotion* literature between *public health* and a new public health for the purposes of emphasizing significantly different approaches to the description and analysis of the *determinants of health*, and the methods of solving public health problems. This New public health believes in a comprehensive understanding of the ways in which lifestyle and living conditions determine the health status and recognition of the need to mobilize resources and make sound investment in policies, programmes and services, which create maintain and protect health by supporting healthy life styles and creating supportive environment for health."[5]

All public health manager today therefore need to see public health as a multi- dimensional challenge which includes the following:

Does your public health management include all this?

- Protecting people's health.
- Promoting people's Health.
- Restoring peoples health.
- Maintaining and improving health of people through
  - Collective action.
  - Social action.
- Programmes emphasizing prevention not just cure.
- Programme addressing health needs of the population as a whole.
- Reducing the amount of disease, premature death and disease produced discomfort and disability in the population.
- Promoting healthy life styles among the population.
- Helping to create supportive environment for health in communities.

b) District Health System:

A district has been described as the most peripheral organised unit of the local self government and administration for development, health and many other activities. However in large countries like India, Bangladesh, and Indonesia even a district may be too large an entity and subdistrict units may be designed. For the purpose of this document we are primarily using a set of World Health Organization definitions, as most reresentative and applicable to the countries of our region.

The district

> ". ....the most peripheral fully organised unit of local government and administration. It differs greatly from country to country in size and degree of autonomy, and population may vary from less 50,000 to over 300,000.
>
> It is geographically compact and every part of it can normally be reached within a day. As a unit, it is small enough for the staff to understand the major problems and constraints of socioeconomic and health development, and for health and other workers to know each other and be more humane in their approach. It is also a large enough unit for the development of the technical and managerial skills essential for planning and management. There usually is a central administrative point where the main government sectors are represented. The district is often the natural meeting point for "**bottom-up**" planning and organization and "**top-down**" planning and support and is, therefore, a place where community needs and national priorities can be reconciled.
>
> **The district** offers great opportunities for effective inter sectoral action since it is an area within which bodies such as development committees and district councils can very easily plan and act in unison. At district level, away from rigid central divisions and bureaucracies, different sectors have always tended to work together and people find it easy to collaborate on specific issues. The constitutional, legal, political, and administrative structures will determine the degree to which responsibilities will be decentralised. These structures also influence to which also influence the amount of community participation through, for example, representative assemblies or other established mechanisms for the involvement of citizens in public matters."[6]

Health system

"A **Health system** is the complex of interrelated elements that contribute to health in homes, educational institutions, workplaces, public places and communities, as well as in the physical and psychosocial environment and the health and related sectors." [7]

> "A **health system** comprises all organizations, institutions and resources devoted to producing actions whose primary intent is to improve health. Most national health systems include public, private, traditional and informal sectors. The four essential functions of a health system have been defined as service provision, resource generation, financing and stewardship" [8].

District health system

> " A district health system based on primary health care is a more or less self-contained segment of the national health system. It comprises first and foremost "a well defined population living within a clearly delineated administrative and geographical area. It includes all the relevant health care activities in the area, whether governmental or otherwise. It therefore consists of a large variety of interrelated elements that contribute to health in homes, schools, workplaces, communities, the health sectors, and the related social and economic sectors. It includes self care and all health care personnel and facilities, whether governmental or non-governmental, up to and including the hospital at the first referral level, and the appropriate support services, such as a laboratory, diagnostic, and logistic support. It will be most effective if coordinated by an appropriately trained health officer working to ensure as comprehensive a range as possible of promotive, preventive, curative and rehabilitative health activities." [9]

Reflect on your district and the district health system under your charge.
Do these definitions fit your district?
If so, why?
If not, why not?

c) **Health for all**

> "In 1977 the Thirtieth World Health Assembly decided that the main social goal of the governments and WHO in the coming decdes should be the attainment by all the people of the world by the yaer 2000 of a level of health that

would permit them to lead a socially and economically productive life. This goal is commonaly known as "health for all by year 2000". **"Health for all"** is a process leading to progressive improvement in the health of people, not a single, finite target. It will be interpreted differently by each country in the light of its social and economic characteristics, the health status and the morbidity pattern of its population, and the state of development of its health system. However, there is a health baseline below which no individuals in any country find themselves; *all* people in *all* countries should have a level of health that will permit them to work productively and to participate actively in the social life of the community in which they live.

Health for all does not mean that in the year 2000 doctors and nurses will provide medical care for everybody in the world for all their existing ailments and that no body will be sick or disabled. It does mean that health begins and is fostered or endangered at home, in schools and in factories, where people live and work. People will use better approaches than they do now for preventing disease and alleviating unavoidable illness and disability, and have better ways of growing up, growing old and dying in dignity.

Essential health care will be accessible to all individuals and families, in an acceptable and affordable way, and with their full involvement. There will be an even distribution among the population of whatever resources for health are available and people will realise that they themselves have the power to shape their lives and the lives of their families, free from avoidable burden of disease, and aware that ill-health is not inevitable." [7.]

Relect on what "Health for all" could mean for the people in your district.

What is the essential health care that will be accessible to all individuals and families in an acceptable and affordable way with their full involvement in your district?

What resources for health would be available and distributed to all people in your district?

d) **Primary health care**

"**Primary health care** is essentail health care made accessible at a cost the country and community can afford, with methods that are practical, scientifically sound and socially acceptable. Every one in the community should have access to it, and every one should be involved in it. Related sectors should also be involved in it in addition to the health sector. At the very least it should include education of the community on the health problems prevalent and on methods of preventing health problems from arising or of controlling them; the promotion of adequate supplies of food and of proper nutrition; sufficient safe water and basic sanitation; maternal and child health care, including family planning; the prevention and control of locally endemic diseases; immunization against the main infectious diseases; appriorate treatment of common diseases and injuries; and the provision of essential drugs.

Primary health care is the central function and main focus of a country's health system, the principal vechicle for the delivery of health care, the most peripheral level in a health system stretching from the periphery to the centre, and an integral part of social and economic development of a country. The form it takes will vary according to each country's political, economic, social, cultural and epidemiological patterns. To be successful it needs individual and community self reliance and the maximum **community involvement** or participation, that is to say, the active involvement of the people living together in some form of social organization and cohesion in the planning, operation and control of the primary health care, using local, national, and other resources. The term "involvement" is preferable to **"participation"** because it implies a deeper and more personal identification of members of the community with primary health care. In community involvement individual's and families assume responsibility for their, and the community's, health and welfare and develop the capacity to contribute to their own and the community's development. Part of such responsibility is **self care** which implies largely unorganised health activities and health- realted decision making carried out by individuals, families, neighbours, friends and workmates. These Include the maintenance of health, prevention of disease, self diagnosis, self treatment, including self medication and self aplied folowup care after conact with the health services"[7].

"Primary Health Care" is traditionally being used to mean first level conact between patient or communities and organised health care. In this sense it includes the services provide by prepheral health workers, including general practitioners, nurses and health auxiliaries. ..... the expression conveys two other meanings: essential health care consisting of atleast eight elements (see figure), and an approach to the provision of health care that is characterised by

equity, intersectoral action and community participation. It is essentially to these two last meanings that the expression now commonly refres "[6].

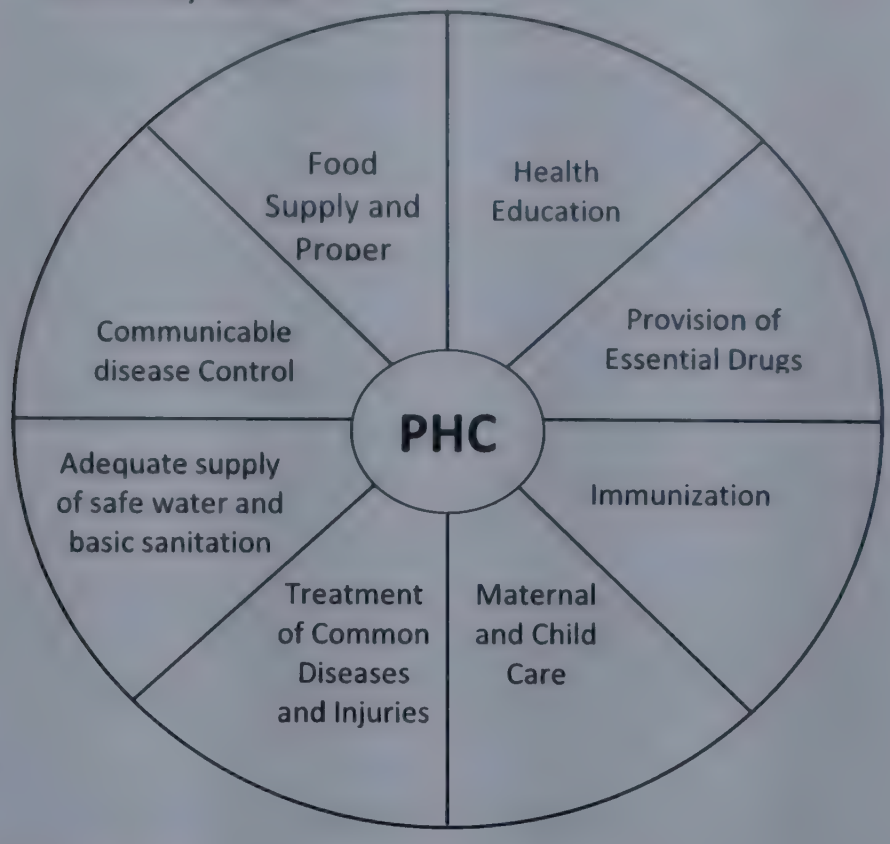

Fig.1. Eight Elements of Primary Health Care, *Source: 4*

Primary Health care as a core element and component of district health system has seen a recent renewal and revival at health policy level at national, regional and global level. The World Health Report 2008 of the World Health Organization, entitled "Primary Health Care: Now More Than Ever" makes a strong commitment to this revival. It reminds us that people centred primary care should focus on health needs, be comprehensive, continuous and person centred, build enduring relationships, build responsibility for the health of all in the community along the life cycle and take responsibility for tackling determinants of il health and make people partners in manging their own health and that of their communty!"[10].

Values

As part of the recent revival in primary health care some additional core values have been recently outlined as part of primary health care and public health systems. Values have been defined, as social goals or standards, held or accepted by the individual, class or society. Values have recently been outlined for health systems in a recent PAHO document[11] .As this document reiterates "values are essential for setting national priorities and for evaluating whether or not social arrangements are meeting population needs and expectations. They provide a moral anchor for policies and programmers enacted in the public interest" [9]. Many values are universal and hence relevant to health systems in

our region as well. These are, equity, gender, solidarity and health as a right. These are now discussed based on adaptations from recent health policy documents as indicated. Each country in the region need to reflect on these four basic values and identify how they are expressed or distorted in each country so that the positive value orientation can be enhanced by more country specific action plans.

a) **Equity** [11 &12]

All health systems are challenged to address the unfair health differences that exist in

- health status;
- access to health care;
- access to health enhancing environment,
- access to treatment and services within the health and social service systems.

This quest for reaching those who cannot reach or access the system is what is described as equity orientation and in simple language it may be described as **"reaching the unreached"** and **"equal treatment of all subjects".**

Inequity can be due to,

- disadvantage by geography, eg- inaccessible terrain
- marginalization by caste or class or ethnicity (eg- indigenous/ tribal and other oppressed communities in South East Asia.)
- social exclusion by gender, disability, social discrimination or stigma of illness.

Therefore an **equity orientation of the health system** implies that the health system always strives towards treating all people as equals – a situation

> "in which disadvantaged population groups (whether defined by age, gender, race-ethnicity, socio-economic class or residence) can better achieve their full health potential, as indicated by the health standards of those groups in society who are most advantaged. It calls for **affirmative and preferential action** to improve the health of those with the poorest health when they face unjust obstacles to achieving that potential. "[12].

Reflect on the equity status of the district health system under your charge. Is the public health system, which you manage at the district level equity oriented?
Does it constantly endeavour to reach those who cannot reach or access your system?

b) Gender [13-14]

Gender is a important concept in public health and primary health care, not to be misunderstood as simply a matter of difference between men and women in society. It is a more comples value construct that looks at roles, status and power relationships between the sexes in the context of society and access to systems and services.

> "**Gender** is used to 'describe the characteristics, roles and responsibilities' of women and men, boys and girls, 'which are socially constructed'. 'Gender is related to how we are perceived and expected to think and act as women and men because of the way society is organized, not because of our biological differences" [13].

Gender and Health

"Society prescribes to women and men different roles in different social contexts. There are also differences in the opportunities and resources available to women and men, and in their ability to make decisions and exercise their human rights, including those related to protecting health and seeking care in case of ill health. Gender roles and unequal gender relations interact with other social and economic variables, resulting in different and sometimes inequitable patterns of exposure to health risk, and in differential access to and utilization of health information, care and services. These differences, in turn have clear impact on health outcomes". [14]

How does Gender influence Health/ health systems?

'In almost all cultures and settings around the world and across social groups, women have less access to and control over resources than most men, and are denied equal access to facilities like education and training. However, what it means to be a man or a woman varies across cultures, races and classes'[13]

How does Gender influence health status?

Gender influences health status in the following ways and hence health systems have to be geared up to address this influence.

- "exposure, risk or vulnerability
- nature, severity or frequency of health problems
- ways in which symptoms are perceived
- health seeking behaviour
- access to health services
- ability to follow prescribed treatments
- long term social and health consequences"[14].

Reflect on all aspects of the public health systems you manage at district level and identify any aspects of the system that may disadvantage women over men in their access to health services, control over information or resources, ability to follow prescribed treatments or long term social and health consequences ?

If so how can you begin to tackle this gender bias?

c) Solidarity

Solidarity

"Solidarity is the extent to which people in a society work together to define and achieve the common good" [11].

Manifestation of solidarity

"It is manifested in national, state level and local government; in village self government like panchayatraj in India; In the formation of voluntary agencies both ngo's and community based organizations; trade unions and others forms of citizen participation at a community level- be they farmers clubs, women's clubs, youth clubs and teachers clubs/societies" [11].

In the plural societies like those we have in South Asia, sometimes, religion, caste and ethnic difference can divide this community solidarity, and produce tensions leading to a temporary break down of solidarity. Public health systems and primary health care based health systems require and should promote solidarity as a value so that there can be social solidarity in enhanced health investments, risk pooling and help in building solidarity across community boundaries; across sectors and across plural sections of society.

In your district reflect on the religion, ethnic and other divisions and stratification in your community.

Do these in any way produce any tensions in the community or between some sections of the community and your health system? How can you tackle this challenge amd promote solidarity?

d) Health as a Right

The constitution of the World Health Organization adopted in July 1946, by 61 states and which came into force on 7th April 1948 clearly states that **'the enjoyment of the highest attainable standards of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic and social condition'** [15]. The Alma Ata Declaration of 1978 reaffirms this fundamental right and further specifies that "**The attainment of highest possible level of health is a most important worldwide social goal"**[16] whose realization requires the action of many other social and economic sectors in addition to health sector.

Right to Health

This has been "legally defined as rights of citizens and responsibilities of government and other actors and creates health claims for citizens that provide recourse when obligations are not met. The right to the highest attainable level of health is instrumental in assuring that services are responsive to people's needs, that there is accountability in the health system, and that PHC is quality-oriented, achieving maximum efficiency and effectiveness while minimizing harm." [11]

In many countries of South East Asia, strong civil society initiatives and social movements are strengthening the value orientation of health systems towards the right to health with governments, specially in Thailand and India evolving health policy and health systems responses imbued with this value.

Reflect on the programmes that the public health system managed by you is offered to the community.

Are these programmes oriented to a rights-based approach or are these seen as charity or just services?

What can you do to make them more oriented to health as a right?

As part of the strengthening of public health management in the region there is need for managers to re-look at many more concepts and definitions frequently used in a public health systems context but often forgotten or distorted in practice. A collection of commonly used terms which are important for district health management is included as additional reading in appendix -1. These are taken from standard WHO sources and related literature. Since they are essential for good managemnt practice take time to reflect on them and understand their significance and context.

SOME COMPONENTS

a. Health promotion[5]

Health promotion is the process of enabling people to increase control over, and to improve their health.

Health promotion represents a comprehensive social and political process, it not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health. Participation is essential to sustain health promotion action.

b. Advocacy for health[5]

A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme.

c. Alliance building [5]

An alliance for health promotion is a partnership between two or more parties that pursue a set of agreed upon goals in health promotion.

Alliance building will often involve some form of mediation between the different partners in the definition of goals and ethical ground rules, joint action areas, and agreement on the form of cooperation, which is reflected in the alliance.

d. Health communication[5]

Health communication is a key strategy to inform the public about health concerns and to maintain important health issues on the public agenda. The use of the mass and multimedia and other technological innovations to disseminate useful health information to the public, increases awareness of specific aspects of individual and collective health as well as importance of health in development.

e. Healthy public policy[5]

Healthy public policy is characterized by an explicit concern for health and equity in all areas of policy, and by an accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes healthy choices possible or easier for citizens. It makes social and physical environments health enhancing.

COMMUNITY ORIENTATION

a. Community[7]

A specific group of people, often living in a defined geographical area, who share a common culture, values and norms, are arranged in a social structure according to relationships, which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms, which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them.

In many societies, particularly those in developed countries, individuals do not belong to a single, distinct community, but rather maintain membership of a range of communities based on variables such as geography, occupation, social and leisure interests.

b. Community Involvement[7]

The active involvement of people living together in some form of social organization and cohesion in planning, operation and control of the primary health care, using local national and self resources.

The term involvement implies a deeper and more personal identification of members of the community with health care In community involvement individuals and family responsibilities for their, and the communities health, welfare and development.

c. Community action for health[5]

Community action for health refers to collective efforts by communities which are directed towards increasing community control over the determinants of health, and thereby improving health.

d. Empowerment for health[5]

In health promotion, empowerment is a process through which people gain greater control over decisions and actions affecting their health.

Empowerment may be a social, cultural, psychological or political process through which individuals and social groups are able to express their needs, present their concerns, devise strategies for involvement in decision-making, and achieve political, social and cultural action to meet those needs.

SOME HEALTH SYSTEM BASICS

a. Determinants of health[5]

The range of personal, social, economic and environmental factors, which determine the health status of individuals or populations.

b. Health behavior[5]

Any activity undertaken by an individual, regardless of actual or perceived health status, for the purpose of promoting, protecting or maintaining health, whether or not such behaviour is objectively effective towards that end.

c. Health indicator[5]

A health indicator is a characteristic of an individual, population, or environment which is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population (quality, quantity and time).

d. Health policy[5]

A formal statement or procedure within institutions (notably government) which defines priorities and the parameters for action in response to health needs, available resources and other political pressures.

e. Health sector[5]

The health sector consists of organized public and private health services (including health promotion, disease prevention, diagnostic, treatment and care services), the
policies and activities of health departments and ministries, health related nongovernment organizations and community groups, and professional associations.

f. Social capital[5]

Social capital represents the degree of social cohesion which exists in communities.
It refers to the processes between people which establish networks, norms, and social trust, and facilitate co-ordination and co- operation for mutual benefit.

g. Network[5]

A grouping of individuals, organizations and agencies organized on a non-hierarchical basis around common issues or concerns, which are pursued proactively and systematically, based on commitment and trust.

'BEYOND THE PUBLIC HEALTH SYSTEM' CHALLENGES;

a. Social responsibility for health[5]

Social responsibility for health is reflected by the actions of decision makers in both Public and private sector to pursue policies and practices, which promote and protect health.

b. Supportive environments for health[5]

Supportive environments for health offer people protection from threats to health, and enable people to expand their capabilities and develop self reliance in health. They encompass where people live, their local community, their home, where they work and play, including people's access to resources for health, and opportunities for empowerment.

c. Inter-sectoral collaboration[5&7]

A recognized relationship between part or parts of different sectors of society which has been formed to take action on an issue to achieve health outcomes orintermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone.

Inter-sectoral action for health is seen as central to the achievement of greater equity in health, especially where progress depends upon decisions and actions in other sectors, such as agriculture, education, and finance. A major goal in inter-sectoral action is to achieve greater awareness of the health consequences of policy decisions and organizational practice in different sectors, and through this, movement in the direction of healthy public policy and practice. Not all inter-sectoral action for health need involve the health sector. For example, in some countries the police and transport sectors might combine to take action to reduce road transport injury. Such action, although explicitly intended to reduce injury, will not always involve the health sector. Increasingly inter-sectoral collaboration is understood as cooperation between different sectors of society such as the public sector, civil society and the private sector.

Medical pluralism:

The term medical pluralism is vast and can be used to envisage many a concepts. Pluralism has not received the critical attention it deserves hence this chapter has not adequately explored the overall issues related to pluralism. The context/concept of medical pluralism should not be limited to the choice of treatment and perceptions / responses of people to various systems of medicine.

The meaning of pluralism should be extended further to incorporate pluralism among the medical practitioners. The medical practitioners in India range from professional degree holders to persons without any qualifications. There

is "considerable evidence" that a general medical practitioner will draw from all systems of medicine in his practice. Eg. Incorporation of stethoscope and ophthalmoscope by the ISM and use of Liv-52 by their counterparts. "The ISM practitioners use biomedicine and germ theories in their explanatory armoury while a biomedicine practitioner's use Ayurveda hot-cold dichotomy for dietary restrictions"[17].

With the references to above background and for practical purposes the term medical pluralism can be defined as 'Respect', 'tolerance', 'co-existence' and 'interaction' along with 'assimilation' between the various systems of medicine/health without 'conflict'[18].

Addressing the issues of Respect, Tolerance, co-existence, interaction and assimilation will help in understanding the basis for prejudice between the systems of medicine; however this would also significantly help in facilitating discussions between various systems of medicine. These form an important measure for realization of Integration of medical and health systems. Every system of medicine can contribute to health care in their own way; a national health system should ensure that good services and human resource available with Traditional System of Medicine to be utilised on the basis of non-discrimination.

Partnership for health [5]

A partnership for health is a voluntary agreement between two or more partners to work cooperatively towards a set of shared health outcomes

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2. A New Frame Work For Public Health Management: Roles, Skills and Challenges

2.1. Exploring Plurality and diversity of the the health systems in the region

The network of manpower and facilities providing health care at district level varies with in the country. For a better understanding it can be divided into four groups: within the community; at the community level; at the intermediate level and at the district leve[1].

a) **Within the Community:**
Within the community, itself there may be community health workers. Also, many Individuals, families, groups with in communities and other sectors will be involved in health care activities. These also have different names, 'Multipurpose workers MPW- M/F, Aanganwadi worker- AWW, and Accredited Social Health Activists -ASHA's'; [1].

b) **At the community Level:**
At the most peripheral level of contact between the community and the organised health service, there are health units with different names in different countries, eg: 'Primary Health Center and Sub-centers' ; [1]

c) **At the Intermediate Level:**
In between the community level and the district level there are other units depending on the size and the geographical spread of the population. 'Community Health Centers' –'CHC' [1]

d) **At the District level:**
Somewhere in the district, usually in the main town, there is a district hospital. These also have different names, eg: 'District Hospitals' (India); There may be also other hospitals, often belonging to non-governmental organizations such as missions and societies.

2.2. The Public Health Management Challenge: system and team

The is the manager of an increasingly complex and challenging District level health system which has grown in more recent years to an aggregation of many components, characterized by the following features and complexities. Inspite of the plurality and diversity in the region (outlined in earlier section), we have attempted to build a generic framework for district health sytems. This framework consists of the folowing;

- A multilevel health system
- A mutli- member health team
- Generic skills required for public health management.

a) A multi-level health system

As outlined in an earlier section, in most 'South East Asian countries'[1] there are at least four levels in the typical district health system.

Level One: The village or 'community level' characterized by village health committees and village health workers working in association with traditional birth attendants and local healers.

Level Two: A sub centre or health post staffed by paid 'nurses' / 'midwives' / 'multipurpose workers' or 'auxiliaries' which can provide diagnostic and outpatient services and antenatal, under-five and 'midwifery' services. Sometimes they have a few beds to hold acutely ill patients for awhile or treat acute dehydration or other similar conditions.

Level Three: The 'Primary Health Centre' and or the 'community health centre' which is staffed by 'doctors', and 'medical assistant's' 'nurses'/ 'midwives', 'laboratory technicians' and other grades of community oriented workers (nutrition, environmental health, sanitarian, etc.) [1]

Level Four: The district level centre and or hospital which supervises multiple PHCs and is responsible for planning, administration and support of health centers, health posts and health programmes throughout the district. Depending on the size of the country and its division into states / provinces sometimes, this District level is a network of sub-district level, decentralized, administrative units.

Above Level Four : The district health system links into the state level and or national level health system under the Ministry of Health.

The first complexity of the managers role is to be able to

- **understand, delineate and operationalise which level can undertake what type of activity / service.**
- **how will each level refer to the next level if the problem to be tackled is beyond the competency / resources of that level.**

b) A multi member health team

The District Public Health Manager has a large contingent of 'health team' members and auxiliaries deployed at different levels of the system with different but specified roles and responsibilities. Many of them will have 'formal training' with a core or strong component of public health / community health, while many may have undergone short term auxiliary training or in-service/on the job capacity development.

The team consists of doctors and nurses at different levels, 'pharmacists' and 'technicians', 'health educators', 'nutrition workers', 'sanitarians', 'health supervisors', 'multipurpose health workers' and 'auxiliary nurse midwives', 'traditional birth attendants', 'village health workers' and 'special programme workers' like 'child care workers', basic health programme workers linked to specific disease / health programmes and other paramedical or allied health professionals.

The second complexity of the Manager's role is to

- **understand, delineate and operationalise the role and functions of each member of this complex health team.**
- **plan and operationalise a supportive supervision of each team member by another member of the team at the same or next level;**
- **plan and operationalise some on the job and some off the job continuing education and regular updation of skills and capacities of every team member.**

The District Public Health Manager, often also called the District Health / and or Medical Officer, does not work alone or in isolation. In addition to all the above team members who are usually subordinate to him there are at the district level, programme officers like the District TB Officer, District Malaria Officer, District MCH or Family Planning Officer, etc and other district level officers like nurses, environmental health officers, senior sanitary inspectors, health educators, district level child care and or nutrition officers, district level pharmacists, dentists, and various administrative and finance officers – **all together forming a district public health management team**.

It is important that there is a well developed sense of team spirit in this group and it is also important for them to work in a sort of networking and collaborative way carrying out different functions but working towards common goals. The team approach includes better joint decisions, a common vision / mission, ability to speak with common voice and evolve policies through consensus and also evolving policies and mechanisms to handle differences of approach and perceptions.

c) Generic skills required for public health management

District Public Health Managers need a wide variety of generic public health / management skills to tackle the diverse and complex challenges of their roles and responsibilities. **This manual emphasises this generic nature of district public health manager's roles and responsibilities irrespective of their specific designation or focused function.** The main skills included in this document are as follows;

- *How to make a district diagnosis ?*
- *How to organise a health management information systems ?*
- *How to evolve a district plan ?*
- *How to organise an epidemiological surveillance system ?*
- *How to respond to an epidemic /managing an out break?*

- *How to manage health programmes?*
- *How to manage human resource?*
- *How to organise materials management: Drugs, equipment and facilities?*
- *How to monitor and evaluate?*
- *How to develop good leadership?*
- *How to promote, communicate and advocate for health?*
- *How to promote and sustain community participation?*
- *How to build and sustain other partnerships?*

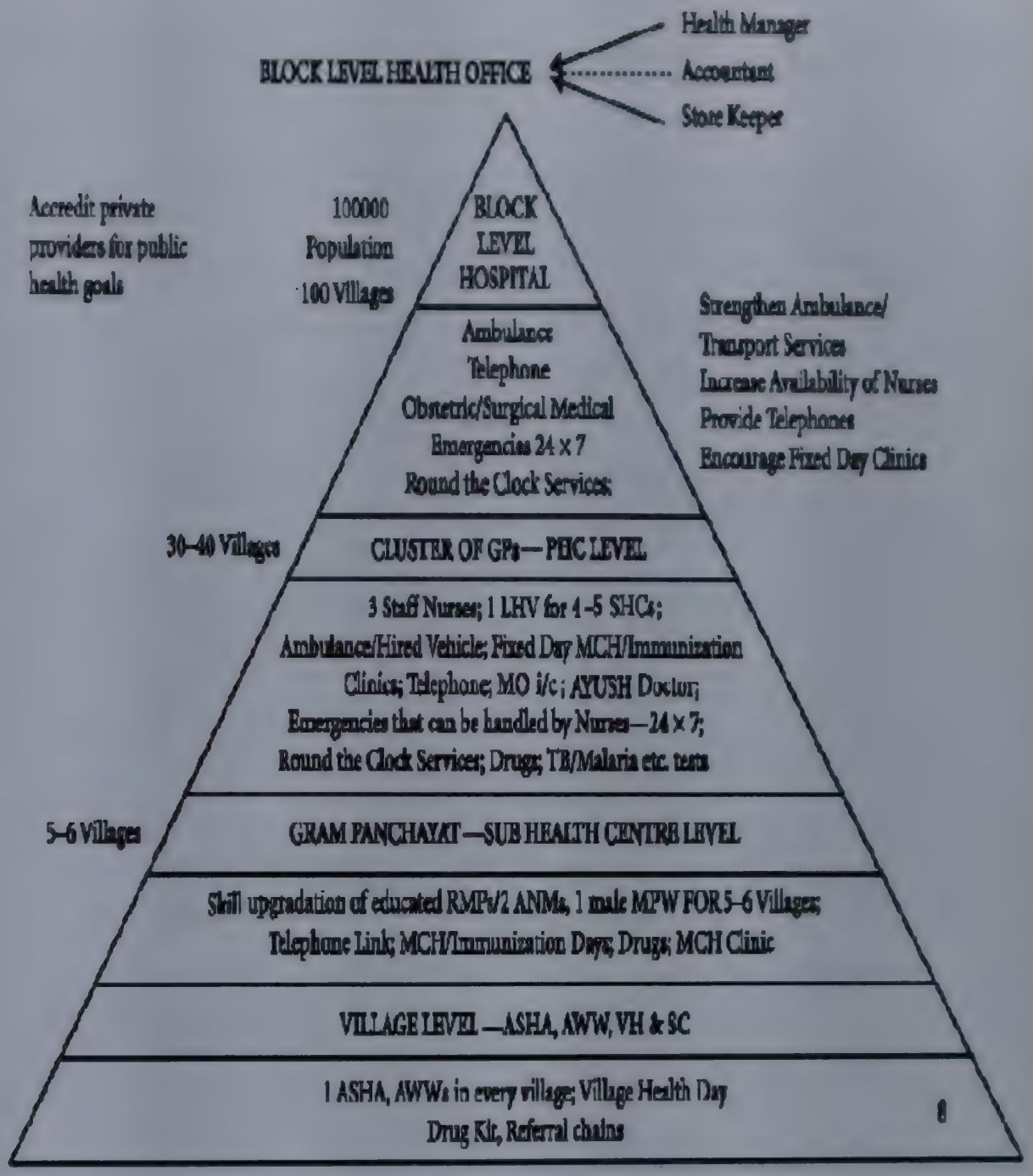
Different countries in the region may have additional functions alloted to the district manager of public health programmes. These may be added as this document gets adapted to the country level for capcity building.

2.3. Evolving a multi level, public health skills framework as a continuum from the grass roots to the district level

At the consultation[2] held as part of the process for evolving the framework and content of this manual a recently evolved multidisciplinary / multi-agency / multi professional public health skills and career framework evolved by the Public Health Resource Unit of the National Health Services in UK was presented as a case study and model for emulation in the region / country. This had been a serious and significant policy evolution to strengthen the public health skills and capacity at different levels of a system and also greatly enhance the learning opportunities for public health skills and capacity development in the country.

Four aspects of this new exercise in the NHS – UK[3] context had significant relevance to the public health systems in the region.

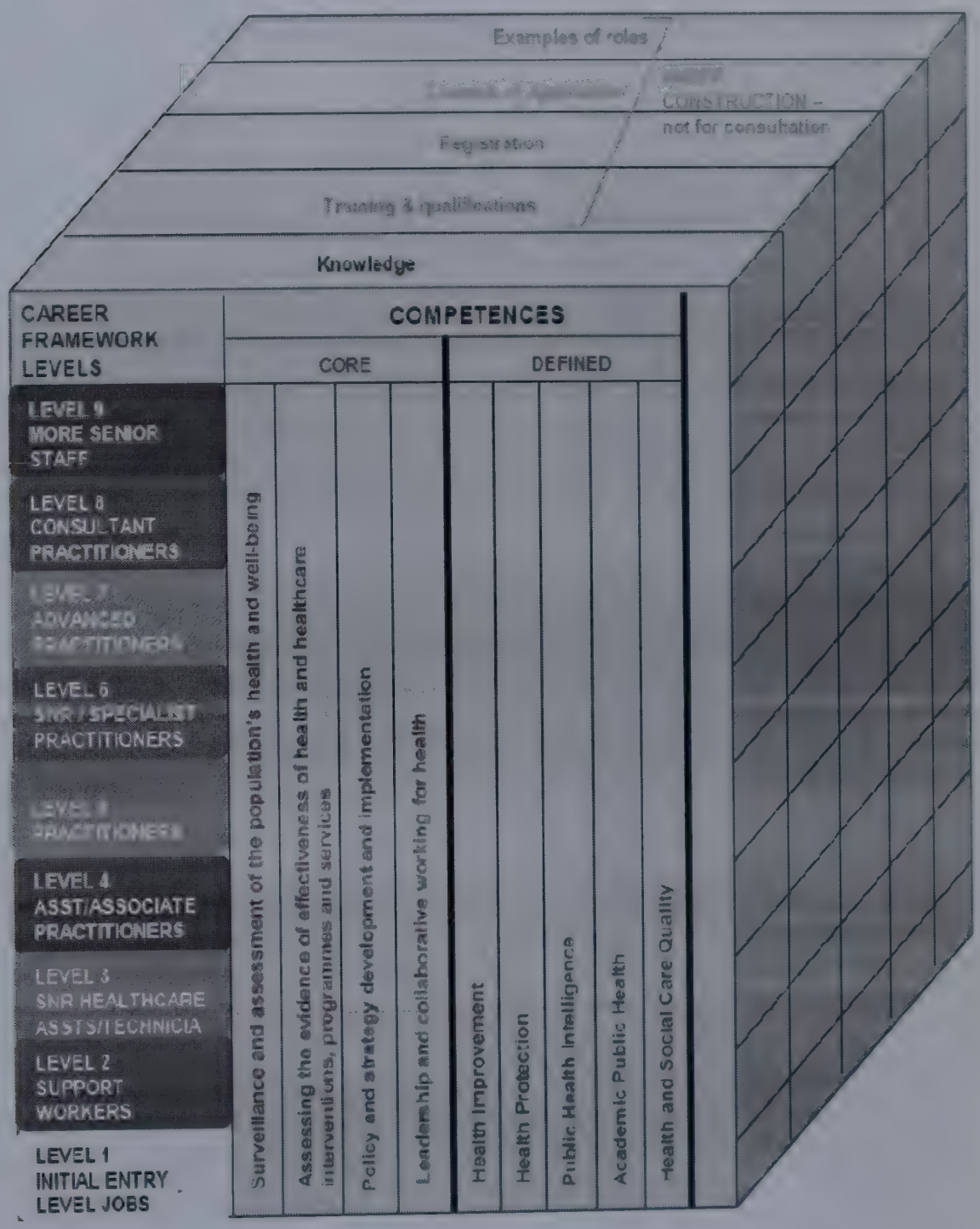
a) There is need to clearly delineate the multilevel structure of the District Public Health system pyramid with the district hospital at the top of the pyramid; the primary health centre and cluster of GP clinics and community health centres at the centre of the pyramid, the sub-centres and gram panchayat run health centres at the panchayat level, and finally a team of community based village workers be they CHWs, health activists, rural midwifes, TBAs and local healers.



Notes: TB – Tuberculosis, MO – Medical Officer, MCH – Maternal and Child Health.

Diagram 1: Source, Social Sector Volume II, Eleventh five year plan, p65.[4]

The Structure of the Framework – The Public Health Skills & Career Framework Cube



Digram 2; Source, Public Health Resource Unit, Multidisciplinary/Multi-Agency/ Multi-Professional/Public Health Skills And Career Framework-Final Draft, p9.[3]

ix. Health and social care guidelines

In the region, there will be need to adapt these to our own public health system levels and challenges evolving our own core and non core areas.

See the Public Health skills and career framework cube

c) The third idea which is good from this model is that we can see these core competencies and defined competencies as a sort of skill continuum so that at the ground level all community based health workers have these skills in its basic community oriented format.

As the worker moves up in his /her career to other levels of the public health skill pyramid, they may be expected to have move complex and sophisticated versions of these same skills and competencies and these skills may be acquired by in-service staff development; new courses and degrees or in-service continuing education.

d) The fourth idea from this new framework is the recognition that there are staff within the public health delivery system at different levels and similarly there are additional work force that can influence the determinants of health. A constant process of identification of these two broad groups of stakeholders as partners in the same

2.4. Some new challenges

With increasing recognition or understanding of social, economic, political, cultural and ecological determinants of health and their impacts on public health system development some newer skills / capacities are also evolving as crucial challenges to district level public health managers. A consultation held as a part of the process evolving this document highlighted some of these challenges[5]

a) **Leadership and decentralized governance**

There are growing concerns about instances of corruption and lack of leadership at the district level. The attitude of passively being a silent spectator to corruption also needs to be changed to becoming more proactive and taking responsibility for change.

b) **Public Health Law and Ethics**

With greater understanding and evolution of the 'Rights paradigm' on the hand and the increasing de-ethicalisation of the market driven development of medical / health care and policy on the other hand the public health manager must be conversant and skilled in handling issues of Public Health Law, Ethics and Right to Health.

c) **Research, innovation and development**

There is constant need to gather evidence of the action and evidence of the impact. Therefore, Research and Development skills and ethos becomes an important part of the district level challenge. Constant monitoring and evaluation; participatory and action research and the awareness and skill in deployment of quantitative and qualitative approaches to evidence gathering for health policy change or health system development is an important and evolving new skill challenge for the manager.

d) **Crisis Management skill**

Finally, while the overall public health management approach and skills are focused on the average district profile, the increasing complexity of larger economic, social and political determinants on the emerging situations and challenges at district level require public health managers to be ready and alert to new emerging situations and unexpected developments at district level, which can have a health significance and impact. For the purposes of this manual, we have called this – ***a crisis management skill***. A number of scenarios come to mind from recent developments in the region. These include:

- **Rapid urbanization** and growth of urban slums due to unplanned urban development and epidemics of ill health in these clusters.
- The increasing marginalization and **displacement of communities** due to mega development projects, deforestation, and special economic zones etc and the emergence of temporary and permanent camps.
- **Natural and manmade disasters** and their effects on the economy, life style, development and health of affected communities e.g. Earthquakes, Tsunami, Cyclone affected district.
- **Large-scale migration** due to drought, labour shortages and development contracts leaders to import diseases.
- **Conflict** including small and large wars, and social and ethnic unrest. (the insurgency in many parts of country)
- **Climate change** and its effects on the ecosystem and health situation – Flooding and or drought situation.
- Finally, the global, national, local **economic downturn** and its effects on health systems at district and community levels.

All these challenging situations in a district need additional gearing up by existing public health management systems to meet new challenges, new health emergencies and new crisis situations.

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3. Towards An Integrated Paradigm for public health programmes

3.1. Why Integrated Approach?

Public health, health systems and primary health care have always had an Integrated and comprehensive framework of understanding – viewing all the health problems that are faced by a community and population, in a integrated, comprehensive and holistic way. From time to time these problems and challenges have been quantified for magnitude of the problem and qualified for their seriousness or complexity, to help evolve a public health response to the problem. These responses can be through services, skills training and health promotion. Problems may be prioritized and the same may be tackled more intensively or in a more focused way based on the epidemiological realities but the public health lens is always integrated and comprehensive. It always sees the whole problem not just part of it.

In recent years however due to development of international health programmes and partnerships that focused on single diseases, single health problems or single health challenges- various selective, vertical and compartmentalized health programmes have distorted this integrated and comprehensive public health lens. Studies on such externally funded projects and their effects on the integration and sustainability of public health sytems have been reported in recent literature [1].

Public Health Managers nowadays often see themselves as TB programme managers, Malaria programme managers, HIV /AIDS programme managers/ MCH programme managers and more recently the managers of Non communicable disease programmes, rather than integrated public health managers. This manual takes a positive step towards countering this distortion and tries to promote the reality that all of us are and should be **integrated public health managers**. We must not lose this broader vision irrespective of the specific nature of our current duties.

3.2. The challenge of convergence of health programmes

A cross cutting theme of this manual is the need for promoting an integrated approach to health problems. In recent years, the selectivisation, verticalisation and compartmentalization of health programmes has resulted in the District Public Health Manager having to deal with a large number of disease or health related programmes as a series of vertical initiatives with

- their own framework of management;
- their own health management information system;
- their own protocols of monitoring and evaluation;
- their own components of health promotion and policy advocacy.

Apart from duplication of effort and resources this compartmentalization also distorts the health system, and disintegrates it into a series of competing programmes with divergent needs. The health team is confused, often overworked and often in a continuous frenzy of crises management. It has to constantly respond to varying demands of different programmes and competing events and resources. The public health system is therefore distorted and disintegrated

This manual suggests a more integrated and convergent paradigm of management to tackle this current dilemma. It must be emphasized at this stage, that the **Alma Ata Declaration** and the **Millennium Development Goals** do try and emphasise this comprehensive and integrated approach. In actual programme practice at all levels – international, regional, national, state and even district level, howevere, it is the selective – vertical approach that dominates. Most of this is facilitated by the demands of single health problem oriented programmes which are designed, managed, implemented and monitored by international health agencies.

While the Millennium Development Goals – all 8 taken together, are a good example of the integrated nature of health challenges which require multiple levels and focus of action, the MDGs rather than bringing about integrated approaches have further verticalised and compartmentalized public health systems. This itself is one of the key reasons why the performance vis-à-vis MDGs is so poor at most regions and levels.

To summarise therefore, **the Public Health Management approach in this manual is an Integrated and Comprehensive approach based on Primary Health Care and action on the Social Determinants of Health.**

3.3. Integrated strategies at district level

Integration and convergence of all the health problems in a district is eminently possible if the district public health system manager understands this imperative as a core policy strategy and skill and attempts to integrate at all levels as indicated below.

a) **Primary health Worker level;**
All primary health care workers extending health services to community and family level should be oriented to identifying all the common health problems at family / household level and providing necessary advise for further action and or preventive education.

b) **Centre level;**
All centres providing health care at all levels –from the community to the district level must be oriented to address all the common health challenges through routine history and investigation and provide suitable treatment, other forms of relevant care and advise.

c) **Follow-up level;**

All patients identified in the context of the common health challenges should be treated and followed up adequately to prevent further complications, emergence of drug resistance and the prevention of spread to family members and other contacts.

d) **Health promotion level;**

All health promotion activities at all level – schools, colleges, community level or during community events should include all the common health challenges in that specific district.

e) **Training programme level;**

Training programmes of all grades of health workers including in-house on the job training and continuing education training must include all the common health problems and must stress the need to find convergence and synergies in existing programmes / initiatives / events to address these problems through suitable promotive, preventive, curative and rehabilitative action .

f) **HMIS levels;**

All information for assessments of all the common health problems should be integrated, moving from separate registers and single problem monitoring systems, to a more integrated register and more composite and convergent monitoring systems. This convergence is particularly urgent and important at the level of health workers, who often in the current HMIS systems are being forced to maintain larger number of registers than really required.

This convergence of information will also help gradually to make all the health workers truly multipurpose workers. During community and family visits, each worker may be able to tackle more of the problems of the same family, saving time, effort and resources in the bargain. From the worker level point of view, this integrated approach will be more efficient and welcomed by both the workers and the community.

g) **Drugs/supplies level;**

Drugs and supply logistics and indenting at centre level and at district level will be greatly enhanced in its efficiency by this convergent approach. All drugs and vaccines, diagnostics, and health education materials can be indented procured, transported and distributed in this convergent way, reducing costs and time and effort of human resources, in their acquisition, deployment and distribution.

h) **Monitoring and Evaluation level;**

Monitoring and evaluation of the progress of all the programmes should be integrated in a convergent way. This will help to identify large cross cutting system failures or system lacunae and provide evidence and enthusiasm for system change, modification or new developments.

i) **Externalities management level;**
Dealing with 'externalities' in the programme planning and implementation of all these health problem can also be tackled in a more integrated way learning from each programme and building on convergent and cross cutting themes, problems and challenges . These externalities would include

- community monitoring;
- building local level partnerships to enhance outreach of the services;
- handling political interference;
- tackling leadership and governance problems;
- managing financial crisis;

All forms of system failure requiring crisis interventions can be more easily tackled through a integrated / convergent approach.

To summarise

- This integrated / convergent approach has been the sheet anchor of the comprehensive primary health care approach.
- if incorporated into the present –compartmentalized, verticalised and distorted public health system, it will be a major boost for efficiency, effectivity and impact.
- Integration is not only a management method but also, an attitude of mind – where the whole is not forgotten because of a focus on the part, i.e. the woods are not lost sight of because of the focus on the trees!

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4. How to make a district diagnosis?

Every District Public Health Manager needs to spend some time every year, every month and whenever possible to understand the problems and challenges in her/ his specific district, so that the health systems and health programmes can be adapted to be more responsive to this reality and to this evolving / changing situation.

All managers are expected to collect, supervise, tabulate, analyse and report a large amount of data from the Health Management Information Systems which may be operating within their district system and which may be a part of a more organized National / Country level and State level HMIS. However, often this reporting becomes a routine ritual or activity geared towards supplying data for another level, another manager. This chapter highlights that the primary significance of all data, information, evidence collected at the district / sub-district level as part of an HMIS or as part of routine public health programme activity is primarily to help the Manager make a District Diagnosis which includes sub-district and community diagnosis.

Knowing your own district and all the components related to it – including development situation, demographic situation, health situation, health system situation, local self government, potential partners and everything about the communities you serve – with their diversity and plurality is the first step of the District Diagnosis.

4.1. Preliminary Information To Make A District Diagnosis

In this manual we are suggesting a set of general questions that each district level public health manager must ask his team and in order to get the answer or the basic evidence to evolve the answer. Some further details of components and sub questions are also included. These are not exhaustive but indicative. They are adapted from four well known sources. [1,2 ,3 & 4] Depending on the country / state / and local situation additional questions may be relevant and should be added to the list.

a) Knowing your community

It is possible that the District Public Health Manager does not know everything about every community that is available in the whole district – but it must be his / her endeavour find out as much as possible and to make every health team member aware of the need to make a basic 'community diagnosis' of all the communities, sub-communities, clusters of people living in areas under their defined geographical and jurisdictional areas so that from this multiple community diagnosis – the identification of priority groups whose access, utilization and service satisfaction may be made possible by focused initiatives and actions in every programme and functional area of the district and sub-district health systems.

The community diagnosis must specially focus on

a. the type of community based on geography – rural, urban, hilly, forest dwellers;
b. The type of community based on caste, class, gender and ethnicity with focus on plurality, health seeking behaviours and access and uilization of health programes;
c. The religious, cultural, political divides that need to be kept in mind so that community building activities to address these divides can be built into the health programmes.
d. The presence, status and special challenges of smaller marginalized or socially excluded groups within and outside the mainstream community. (These need to be reached, addressed, involved and supported by special activities and focused measures.)

    Eg., women, working children – child labour and street children, school dropouts, people with disability, people with mental ill health, elderly, those who are socially excluded due to social status (dalit and adivasi) and stigma (leprosy, HIV-AIDS, sexual minorities, sex workers)

It is only with such inclusive information that the health system can live upto its mandate to equity in access to health care for all the peoples in the sistrict.

b) What do you know about your own district?

Before focusing on health problems and health systems it is important for the District Public Health manager to know more about the social, economic, political, cutural and ecological characteristics of the district.

a) The geography of the district including its plurality in terms of urban / rural, hilly, forest regions and its physical geography – including water resources.
b) The economic geography of the district which includes the main economic activities – agriculture, industry and other rural / urban occupations; wages and income – averages and ranges;
c) The literacy levels of the population and the educational resources and opportunities in the area – schools, colleges and vocational training facilities and also non-formal educational initiatves.
d) The general development levels of the district – roads and accessibility of regions, electricity and telecommunication; water sources and supplies and sanitation; markets and commercial activities.
e) The social development levels of your district – the social institutions, cooperatives, clubs and societies, the libraries, the availability of media – folk and radio / television and telecommunication.
f) The cultural development of the district in terms of cultures, ethnicities, minority groups, indigenous people and their development and interactions. Also resource for folk and formal cultural communication – art, music, dance, theatre and informal education including jatha, fairs and festivals.

g) The political situation of the district in terms of leaderships, designations and role of important supervisors, chain of reporting etc
h) Various partners in Health and Development sector present in your district
i) Public transport and access. Timing ? Access at night?

C) Understanding ill-health of your district:

Some questions to find answers for:

a) Which age groups contain most people and which age group is increasing fastest? - demographic date by age groups and sex.
b) Who gets sick? Who dies? In the community? In the centres / hospitals? – age and sex specific mortality with causes of death? Morbidity with causes of death by age and sex?
c) Who needs maternity care? - - fertility, live births,still births, infertility.
d) What are the health problems in the area?
    1. What does the dispensary / health centre / hospital / statistics say?
    2. What do the people in the community report when they meet health workers?
e) When does ill health occur? Which months? Which seasons?
f) Why does ill health occur?
    1. nutritional status
    2. physical factors in the community
    3. social and cultural determinants / environment
    4. economic and political determinants
g) Are these health problems specific to certain socially marginalized groups in the district
    1. women
    2. aged / elderly
    3. people with disability
    4. working children / street children/ child labour
    5. dalits, adivasis, sexual minorities
    6. stigmatized by illness – leprosy? / HIV-AIDS?
h) Water supply and sanitation
    1. Source (Protected well, unprotected wells, river, pond, piped water etc)
    2. Toilets, sanitary latrines, fields etc
    3. Village sanitation
i) Disease vectors (mosquitos, flies, sandflies etc)

d) What is right/wrong with the existing district health systems?

a) What are the government linked health systems in the district?
    1. at the district level
    2. at the sub-district level
    3. at the community level

4. at the family level (first level of contact)

b) How are the services coping or performing?
    1. From the health team point of view
    2. From the community leaders point of view
    3. From the community / people point of view
c) Are all the people utilizing the services? If not, why not? Who is not?
d) Is the services covering or reaching all the parts of the district? If not, why not? Where is it not reaching?
e) Are any particular groups in the community considered specially 'at risk' of ill health and is this concept being used in any of the health services and health programmes?
f) Is there a deficit in the:
    1. Quantity of care for district needs?
    2. Is there a quality concept for different services?
g) Is staff morale high? Is health team concept and practice strong?
h) Do staff interact well with the community, patients and each other?
i) Is the health system regularly monitored and evaluated?

e) What Are The Additional Local Resources ? Who Are Your Potential Partners?

a) Who is providing Health Care? Of what type and or how?
(who do people go to for advice? Where? When? At what cost?)
    1. Traditional birth attendants
    2. Traditional healers
    3. Indigenous system/ other system practitioners
    4. General practitioners
    5. NGOs and mission institutions
    6. Private sector.
    7. Government health care institutions
b) Where are the health care providers located in your district ?
(Mapping the different resources on a map to understand spread and outreach and areas that are underserved or in inaccessible terrain will be useful. Where possible include the concept of 'chronobars' ie time taken from villages and clusters to reach the nearest health care facility and referral units)
c) Who are the people other than health workers who also are potential resources for health action?
    1. schools, teachers and children
    2. college, teachers and students
    3. rural development agencies and NGOs
    4. community organizations including farmers' clubs and cooperatives; women's clubs and self-help groups; youth organizations; other community based organizations.,
    5. professional and non-professional literate people, groups, networks
    6. other training institutions

7. other governmental and non-governmental agencies for development, education, rural industry, other sectors which impinge on health.

d) What are the material resources, skills, capacities and local resources (including labour) available from the communities in your district?

e) What are the financial resources that can be tapped to complement / supplement the health programmes under your care?
   1. cooperatives and local banks
   2. local self government institutions and their health budgets
   3. economic activity that can be tapped for contribution / donations, etc.

4.2. Making a District Diagnosis

a) From the categories of information highlighted in the exercise above a description of the following five features of the district will be available:
   1. Type of communities in district
   2. Social, economic, political, cultural and ecological characteristics of the district
   3. Overview of Ill-health in the district
   4. Overview of government health systems
   5. Overview of local resources and potential partners

b) From this collected evidence **a district diagnosis** can be made which would include:
   a) population priorities
   b) health priorities (health indicators)
   c) health care priorities over the year, keeping seasonality in mind
   d) challenges for deployment of resources to ensure coverage of district
   e) sources and quantum of finances and other resources and supplementary / complementary options
   f) special challenges or priorities for the district other than (a) to (f).

c) Since this information collation and diagnosis will be available at sub-district levels at first, the priority health problems and challenges can be identified through a brainstorming with the whole district team and relevant experts. This will help to make an **overall district diagnosis** and explore the programmatic and system responses needed to respond to this diagnosis.

d) ***A district Action Plan*** *can then be drawn up on an annual basis drawn, from all the above exercises and data/evidence collection mentioned earlier. The Action Plan will then consist of a series of action initiatives / elements that need to be then translated into programmes of activity within the context of the multilevel health system in the district and availability of human, material, financial and time resources*

e) Over the years, with more and more decentralization of health system management and health information gathering and decision making, this

process of district diagnosis will no longer be a 'top down' process but a series of 'bottoms up' exercises that begin at the village and community level. Each village or community will initiate this process in coordination with representatives of the local self government structures (constitutionally mandated to manage the most decentralized health functions and programmes) and evolve **village plans**. Multiple village plans will then need to be integrated or compiled into clusters for each sub-district area and finally gradually amalgamated through a series of similar exercises into a District Action plan. An interactive dialogue between stakeholders and participants at each level will add value to this exercise.

f) Additional **Sources of data for district diagnosis and planning** in different countries of the region. There will be additional sources of data, routinely collected or through special surveys which can provide district and sub-district level disaggregated data which will help this diagnosis and planning exercise. These may include.

- Population and household census
- Vital events register – records of vital events such as births, deaths, marriages and divorces
- Routine health services data dealing with morbidity and mortality data; immunization, disease treatment, out-patient attendance and admissions
- Epidemiological surveillance data - including immunization records and notifiable diseases
- Disease registers for specific morbidity and mortality
- Community surveys undertaken by Government agencies, International agencies, Non-Governmental Organizations, research groups, etc
- Research studies by academics

g) Towards a focus on **Qualitative data**

Traditionally the focus of data / evidence gathering for district planning has relied heavily on health systems data be it from an organized HMIS or from monthly reports, clinic and health centre records, stock registers and inventory, survey records and registers maintained and analysed by health team members, - all of which is usually quantitative.

Nowadays it is considered important that all this quantitative data must be supplemented by active qualitative data / evidence gathering which is through listening, observing and talking to community, community leaders, workers and supervisors. These qualitative evidence must include community / beneficiary / consumer / participant feedback as also health team / care provider / supervisor / system managers feedback. Many process, values and other significant qualitative challenges in public health management can be identified and addressed only through such qualitative information seen in the context of the qualitative data from the area.

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5. How to Organise a Health Management Information System (HMIS)?[1]

5.1. What is an HMIS?

A System of systems that allows for the collection, storage, compilation, transmission, analysis and usage of health data that assist decision makers and stakeholders manage and plan resources at every level of health service.

5.2. Why HMIS?

For effective management of health and resources, government at all levels must have interest in supporting and ensuring that health data and information are available as a public good for all stakeholders to utilize.

HMIS will provide reliable, relevant and timely information to health system's policy makers, managers, professionals, and to the other sectors.

5.3. What are the objective of an HMIS ?

- Collecting health data on a regular basis and ensuring its quality.
- Strengthening the ability to analyze the data
- Strengthening the use of the data to make informed and cohesive decisions.
- Assessing the state of the health of the population
- Identifying major health problems
- Setting priorities at all levels

Availability of accurate, reliable, timely and relevant health information is the most fundamental step towards informed public health action. This requires a good HMIS.

5.4. Some Challenges for an HMIS at district level

- Lot of health events at the community level remain poorly recorded and or collected as data. These include births, deaths, and morbidity,
- Health care from Traditional healers, Traditional Birth Attendants, village health workers, patent medicine vendors and others at primary health care level are also not recorded or captured in most HMIS.
- Data from government health facilities is also often inadequate, incomplete, untimely and very little of the total events are captured as data
- Information is hardly available on utilization of facilities, and various components of primary health care

- Data is often collected, compiled and collated, along pre determined formats but analysis for local use is often rarely done.
- Provision for data storage is a common challenge at the lower levels of health care often worsened by the absence or low level of information technology for data processing

5.5 How to organise and or improve a Health Management Information System?

All district managers will usually inherit an existing HMIS that may have evolved gradually over a long period of time in stages and due to the requirments and exigencies of different health programmes. In order to make the HMIS relevant to the district managers efforts to strengthen programme management the following practical steps are suggested. These steps may result in practical modification in the use of the HMIS at the district level or provide feed back to those at the district level or above who are responsible for evolving the HMIS.

Step one:

Review the existing HMIS so as to understand and identify the present weaknesses in the context of:

- Delayed Information
- Inaccurate Information
- Insufficient Information
- Scattered Information.

Reflect with your team how to tackle the reasons for the same and how to overcome them.

Step two:

Identify the essential information needed with indicators appropriate to the district and sub district settings so as to :

- Investigate and contain outbreaks of disease
- Help predict possible outbreaks
- Provide evidence for programme performance
- Identify area with poor programme performance for corrective actions.

Step three:

Use forms prescribed for surveillance according to the national/ state level accpeted format and ensure through constant review:

- Training of health workers to fill the forms in a standardised way.
- Make it easy to use
- Avoid or standardise ambiguous text
- Ensure the addition of crucial instructions

- Review from time to time the problems encountred by health workers in using the forms and provide feed back to those who have palnned the HIMS

Step four:

Facilitate the analysis of data at each level it is collected either using computers or manually. Quality of data improves when those who collect it also use it for planning at their own level.

Step five:

Disseminate analyzed report to both higher and lower levels. Highlight deviation from the normal occurrence while reporting to the next higher level.

Step six:

Validate the data received from various units periodically as a part of the quality control of data.

Step seven:

Co-ordinate with other health sectors for enhancing the coverage of information e.g.

- Private Practitioners
- Voluntary Agencies
- Private Dispensaries/Nursing Homes
- Government Health Institutions
- Railway Hospitals
- Armed Forces Hospitals

Step eight:

Communicate analyzed data and over findings into the public domain (both media and internet) to strengthen public awareness and encourage public suport and action.

Use of Computers in strengthening HIMS

With the growth of Information technology on the region the use of computers is becoming more common in strengthening HIMS. Factors such as cost, local expertise, available software and hardware, and local technical support, will determine the nature and extent of computerization in a specific district level setting. The role of a district manager in enhancing the use of computers in strenghening will include the following.

- Seeking competence at personal level in the use of available technology for HMIS
- Facilitate training of health workers at all levels in use of computers and relevant software and tools prescribed as part of District HIMS
- Increasing quality and efficiency of operation at all levels including expedient recording.

- Enhancing communication of data between members of health team and between levels of the district health system.
- Enhancing use of data for local and team planning which in turn enhance the motivation of the health team to strengthen the health team.

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6. Evolving a district plan ?[1&2]

Health planning should aim at improving the health status of a given population while safe-guarding equity and fairness of access as well as responsiveness of the health system to the perceived needs of the community. The health plan should achieve this goal through the provision of efficient and effective health services, taking into account available resources and the available means and methods of health care.

6.1. Some principles and concepts in planning

- **Elements of health systems.**
  Health planning requires a background understanding of the functioning of the health system in a given country. In any health system, there are three important elements that are highly interdependent, namely: the **community**, the **health service delivery system** and the **environment** where the first two elements operate. (see figure 1) [2]

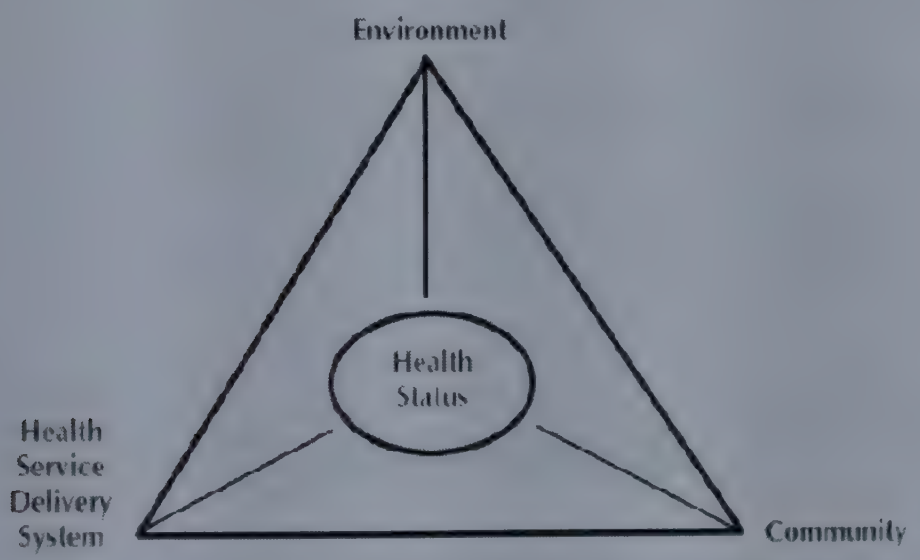


Figure1;Determinats of health status[2]

Community : In the diversity of the region this would include, cultural, ethinic, and religious diffrence as well as charactristics such as gender, marginalisation and social exclusion.

Health service delivery system: This would include health services in the governmental sector as well as those in the civil society, private and traditional/ folk sector. In all of them factors such as coverage, access, affordability and responsiveness to equity and health status would be important.

Environment: As explained earlier the contexual environment would include the social, economic, cultural, political, and ecological detreminants, status and policies relevant to health systems.

- **The Planning cycle**[2]

The planning cycle is a sequence of steps which must be followed in deciding what is to be included in the plan. The cycle seeks to answer the following questions:

Where are we now?

This requires a situational analysis to identify current health and health-related needs and problems

Where do we want to go?

This requires the selection of priorities and identification of objectives and targets to be met in order to improve the health situation and/or service delivery in a district.

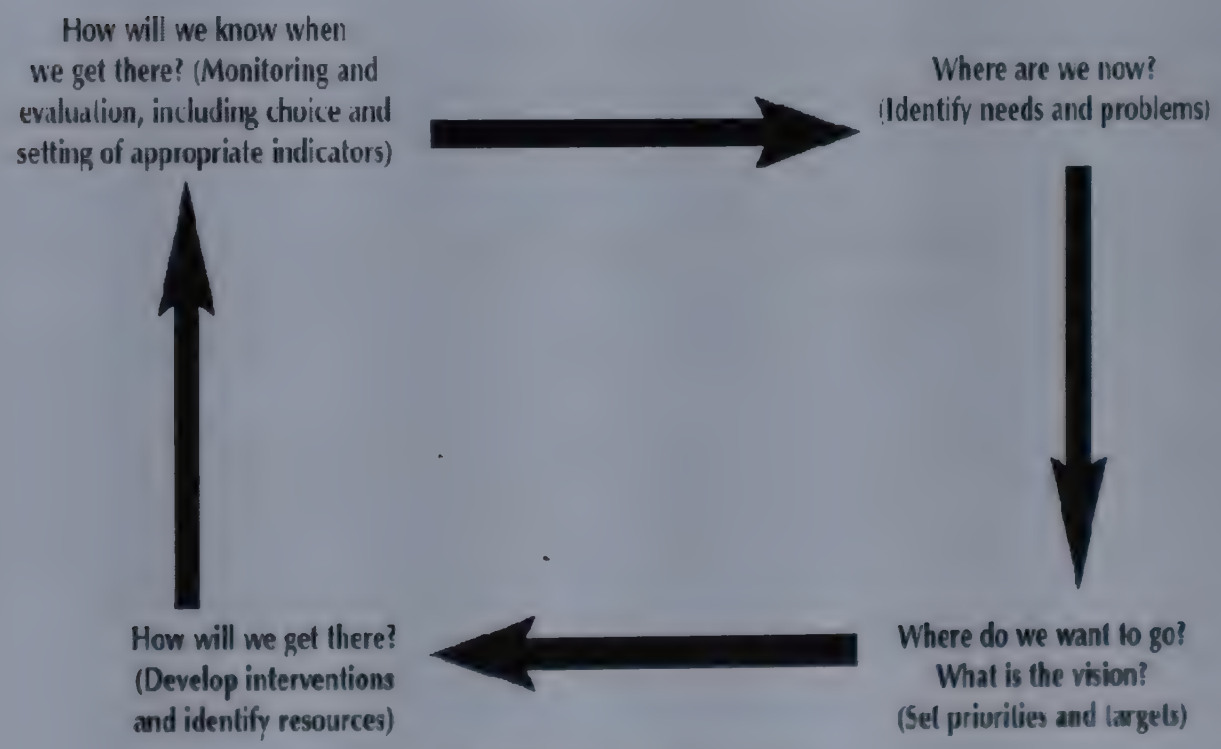
How will we get there?

This details and organizes the tasks or interventions to be carried out, by whom, during what period, at what costs and using what resources in order to achieve set objectives and targets.

How will we know when we get there?

This requires the development of measurable indicators for monitoring progress and evaluating results.

The above questions form a planning cycle as represented in Figure 2.



Planning Cycle [2]

How to evolve a District Health Plan?

The District Public Health Manager along with all his district management team should regularly be involved in a realistic planning exercise as a shared responsibility with each member contributing his / her perception and evidence of the past years programme experience and critically contributing to the development of a annual plan for the district. The process consists of two broad exercises:

i. Reviewing the past year and
ii. Evolving the plan of action for the current year

i. Reviewing the past year

Step One : SWOT

All participants in this exercise should start with reviewing all the programmes they have been involved in during the past year and subjecting it to a SWOT analysis. A SWOT – means Strengths, Weaknesses, Opportunities and Threats. A SWOT is designed so that each planning and implementation team can identify the strengths and opportunities that the team can build on in the future while tackling the weaknesses and threats creatively and collectively

Strengths: achievements, good performances, successful activities and initiatives etc. – What went well and why?

Weaknesses: failures, poor or inadequate performance, unsuccessful efforts – What did not go well and why not?

Opportunities: what new developments took place? what additional resources were identified? What was unexpected but welcome and contributed to the success or achievements?

Threats: What were the obstacles or problems that affected programme performance? What negative developments are posing as a threat to improved and efficient programme responses in the future, what unexpected factors at community or team level could affect programme in the future.

Step Two: Problem analysis and objectives

From the SWOT and supplementing it with evidence and experience of the team, the next step is to identify:

What the problems are?

A problem is a gap between what is and what could be or an obstacle preventing bridging this gap.

There may be more than one problem. Sometimes the analysis of HMIS of the previous year also helps to identify these problems. For each problem identified, it is useful to also discuss the following:

- What is at risk from the problem?
- How do we intend to reduce the problem?
- How much reduction can be expected realistically?

These then when stated as such become the Objectives of the Plan.

Step Three: **Activities**

For each objective (or problem to be tackled) the next step is to break it up into a sequence of multiple activities or steps that will help us achieve that objective.

Activities may be direct services, support activities and development of the service / support.

Sometimes there may be different activities which may meet the same objective but it is necessary to decide which is the most appropriate approach or activity to reach that objective

Step Four: Resource Identification

Having outlined objectives for the year and identified some activities to achieve each objective, we need to identify resources needed and available for each of these activities.

These resources can be human power, equipment and supplies, finance and most important though often forgotten or ignored is the resources of time.

The amount of each resource required also needs to be determined to be able to get an estimate of resource and cost involved.

From these four steps a sort of broad district level plan will evolve but will need a continuing process of wider consultation and dialogue so that the plan is subject to participatory evaluation and dialogue and builds on feedback and suggestions from team members, community and other stakeholders.
For the plan to be operational at a programme level planning has to then be supported by five more steps that establish a framework and provide a more detailed structure.

ii. Evolving the plan

The 5 additional steps to evolve the plan are as follows:

Step One : Situational Analysis

This will include understanding the community; analyse the causes of the main health problems; looking at existing health services; and studying the resources;

Step Two : Problem analysis

This will include defining the causes and solutions of all the health problems to be included in the health planning exercises and prioritising them.

Step 3 : Setting objectives

This wil include setting objectives that are specific, measurable, achievable and relevant, and feasible; which are essential for making plans and evaluating results. All objectives should be converted to operataional targets – which refer to specified activities, populations and periods. The District health team can set its own operational targets by reviewing national and state goals.

Step 4 : Reviewing obstacles and limitations

This review will include questions such as, 'what is or could be preventing the achievement of the objective; limitation of resources – people, equipment, money, information and time; obstacles in the geographical, climate, technical and social environment; to what extent they can these obstacles be removed or reduced and finally a revision of the strategy accordingly.

Step 5 :Finalising the strategy for each objective

Once the objectives and strategies are finalised, then there is need to re look at alternative strategies; make a table of resources needed and available for the different strategies always remembering resources within the community; choosing the most suitable alternative strategy; and finally making a detailed activity schedule with relevant budgets

Through these five steps a practical annual district health plan can be evolved.

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7. How to organise epidemiological survelliance system?[1&2]

The ability to set up optimally functioning disease surveillance system is a critical component of any district health managers resposibility. This 'surveillance section' provides the basic elements and practical approach to setting up and or managing a epidemiological survelliance systems, that will help the district manager and his team be responsive to the disease challenges- both epidemic and non epidemic and help tackling them or taking pre-emptive measures. While ideally an epidemiological survellaince system should focus on all significant health problems in a district, it is usually focussed currently on a nationally predetermined list of key epidemic diseases relevant to that country.

Epidemiology is the fundamental science in public health. Epidemiology helps to understand the natural history of diseases, root causes to promote preventive and therapeutic interventions.

Definition: Epidemiology is "the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to control of health problems"[3]

It is used to

- describe health status of communities – person, place, period
- understand natural history of diseases
- find causes
- evaluate health service interventions.

Therefore, the principles of epidemiology are essential to understand knowledge about community health, practicing skills, attitude and public health values.

Knowledge

- Describe and explain how community health is measured
- List strengths and weaknesses of commonly used health indicators (vital and health statistics)
- Describe epidemiological methods – observational, analytic and experimental
- List strengths and weaknesses of case control and cohort studies
- Explain the distinction between association and causation
- Describe how health surveillance works in practice
- Outline the procedures for investigation of an epidemic
- Explain the epidemiological principles of screening programmes
- Describe the uses of epidemiology in public health policy, planning and evaluation

Skills

- Calculate specific rates and proportions of diseases - incidence, prevalence
- Interpret the data from epidemiological studies and arrive at a logical conclusion
- Distinguish valid from flawed study designs
- Calculate the sensitivity and specificity of screening tests from samples of relevant data

Attitudes

- Be skeptical of, and demand evidence for, opinion statements
- Examine data sources thoroughly before using them
- Demonstrate appreciation of the balance between rights of individuals and collective needs
- Act responsibly in conducting sensitive public health functions
- Respect privacy and protect confidentiality of personal data

Values

- Encourage evidence based district level decision making
- Advocate evidence based managerial/organizational and technical skills to implement health program
- Try to practice evidence based technical, managerial and organizational knowledge at all times
- Promote equity orientation at all level including in analysis of data
- Introduce social audit and concept of accountability and transparency.

7.1. The epidemiological approaches

It will be immensely useful for the district manager if he /she follows the following four epidemiological approaches/steps to understand the health /diseases status of the community.

1. **The first step is the descriptive epidemiology**: It attempts to know the problem by person, place and time by asking the questions such as who is involved, where and when? And finally it wants to know the problem frequency and its distribution in the community.
2. **The second step is analytical epidemiology: This** attempts to analyse the determinants of the health problem and tries to answer the health problem by testing the hypothesis **i.e how and why the problem emerged in the community and how it is continuing?**
3. **The third step is interventional or community experimental epidemiology:** Here the community level program implementation are done to know the effectiveness of interventions and controlling disease conditions.

4. **The fourth steps is called as an evaluation epidemiology:** Where in the effectiveness of different health services or programs are measured to answer health manager's epidemiological questions such as is there an improvement in health status after and before interventions?

Though the descriptive and analytical epidemiological approaches are useful to address the district health problems but descriptive , community intervention and evaluation epidemiology may be very useful and should be frequently used by district health manager.

a)Key Information for epidemiology

The basic epidemiological approach to solve the wide scale health problems depends on the key information. The key health status information is needed to plan, manage and evaluate the activities and for better outcome of community health status. The key information needed may be obtained by asking key questions. Usually 6 questions are considered basic to all epidemiological enquiry. These are:

What is the health problem, diseases or condition, and what are its manifestations and characteristics
Who is affected, with reference to age, sex, social class, occupation and personal habits, attitudes
Where does the problem occur, in relation to place of residence? geographical distribution of problem;
When does it happen, in terms of days, months, seasons or years?
How does the health problem, disease or conditions occur and what is its association with specific conditions, agents, vectors, sources of infection, susceptible groups and other contributing factors?
Why does it occur, in terms of the reasons for its persistence or occurrence?

By presenting the problem as mentioned in the figure in terms of who where and when on a paper will give clear information to the district manager the clarity on the problems to have effective intervention.

i) Measuring frequency

There are two types of frequency measures a) Incidence and b) prevalence
Incidence: is the number of new cases occurring in a community.

- Cumulative incidence= number of new cases during a period / the number of persons at risk in the population **at the beginning of the study**.
  Importance: To know the problem **which is becoming** and to have interventions

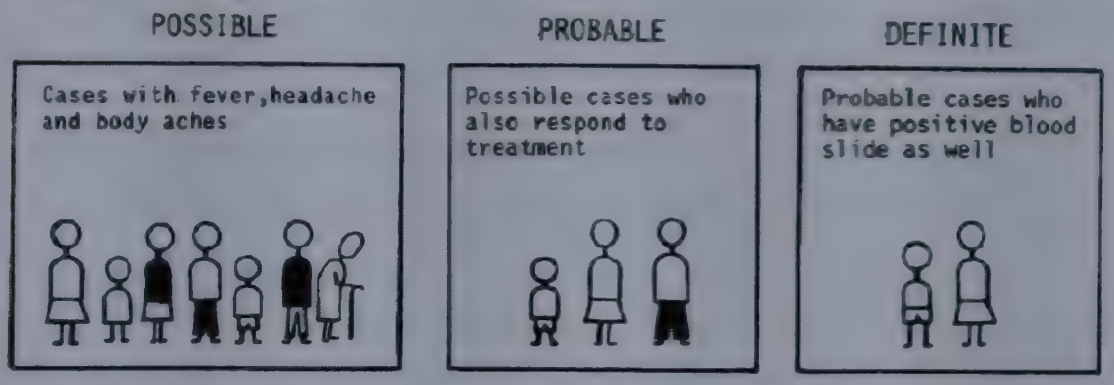
Prevalence: Number of old and new cases

- Point Prevalence = Number of existing cases on a specific date /Number of people in the population on this date
- Period prevalence = Number of cases that occurred in a given period /Number of people in the population during this period
    - *For example: annual prevalence rate, lifetime prevalence rate.* Importance: To know the resources which **became a problem** to provide the health services

ii) Making use of rates & ratios

To calculate the number of cases and expected cases
To compare the two populations

iii) Defining a case



Source: WHO 1989. 'Manual of epidemiology for district health management'[1]

The ability to set up optimally functioning disease surveillance system is a critical component of any health department that delivers the health services. Usually the district health team often struggles to find a guideline or trained manpower to function as a single investigative unit. This struggle or fragmentation of function during disease outbreak is due to blurred roles, responsibilities, and procedures. This 'disease surveillance section' provides the basic elements and practical approach to disease surveillance and how the disease occurrence cycle could be changed so that focused, long-term outcomes will be achieved by pre-emptive measures

7.2. What is surveillance?

Surveillance is defined as the ongoing systematic collection, collation, analysis and interpretation of data and dissemination of information to those who need to know in order that action be taken

<u>In an eppidemiological disease surveillance system it is Important to know</u>

- Who get the disease?
- How many get the disease?
- Where they get the disease?
- When they get the disease?
- Why they get the disease?

- What needs to be done as public health response?

a) Why do we need to do surveillance?

- To recognize cases or cluster of cases to trigger intervention to prevent transmission or reduce morbidity and mortality
- To assess the public health impact of health events or determine and measure trends
- To demonstrate the need for public health intervention programme and resources during public health planning
- To monitor effectiveness of prevention and control measures and prevent outbreaks
- To identify high risk groups or geographical areas to target interventions an guide analytic studies
- To develop hypotheses that lead to analytic studies about risk factors for disease causation, propagation or progression

i) Key elements of a surveillance system

All good surveillance systems are based on the following elements:

- Detection and notification of health events
- Investigation and confirmation
- Collection and consolidation of data
- Analysis and interpretation of data
- Feedback on data
- Dissemination of data
- Action including response for prevention and or control

To have an effective surveillance system, several activities to be undertaken at each level and each survelliance system has to decide what will be carried out at the district level and what wil be carried out that the peripheral level and what will be the relative importance of these activties at those levels.

ii) Reporting units by disease surveillance

The reporting units for diease survelliance can be divided into rural and urban and public sector and private sector.

In each country the categories of institutions in both rural and urban districts and in the private and public sectors should be clearly delineated so that the district manager can involve them in strengthening and contributing to the survelliance systems.

Analysis of the surveillance data.

Surveillance data should be available to all levels of the health system so that each level may participate in contributing to the analysis. Health workers woud identify increase of cases; medical officers in primary health centers would be able to detect outbreaks and epidemics and seasonal trends; and district level staff would be able to do all the above as well as more advanced analysis.

Functions of a surveillance system:

Surveillance systems should help in identification of outbreaks and epidemics; identification of appropriate time for premptive and control merasures; idenfication of health system problems and regional differences with in the district; identification of differences between public and private sector and finally the identification of high risk population groups for each disease under surveliance.

Monitoring of a surveillance sytem:

The district health manager can have better control over the quality of disease surveillance system if he/she monitors seven aspects of the surveliance system at the regular intervals. These inlcude: timeliness /completeness; description by time, place and person; trends over time; threshold levels; comparison between reporting units; comparison between private and public units and comparison between providers with and without laboratory. Form thse different aspects the surveliance system acnb be monitiored and further improved.

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8. Responding to an epidemic /managing an outbreak?[1]

"Remember that an outbreak is usually a sudden and unexpected event. There is a need to act quickly. So a SYSTEMATIC APPROACH needs to be adopted"

When the district authority –usually the district health officer and some times the District Surveillance Officer (DSO), when available suspects an outbreak, he/she should initiate the following steps immediately.

Step 1 - Verification of the outbreak

The preliminary step of the outbreak investigation would be to verify the outbreak. Much time may be wasted due to a false alarm. Even if the outbreak is suspected from the routine surveillance data, it must be verified (lest it may be a data entry error). The fastest way to verify is to contact the MO nearest to the location of the outbreak and request him/her for confirmation. This may be done telephonically or through a special messenger. The MO should check

The fastest way to verify an outbreak is to contact the medical officer (MO) nearest to the location of the outbreak and request him/her for confirmation.

- if there is an abnormal increase in the number of cases or
- if there is a clustering of cases or
- if the cases are Epidemiologically linked or
- if some trigger events have occurred (see above) or
- if many deaths have occurred

If there is evidence of an outbreak, and the clinical diagnosis , the source and the route of transmission is known, then the specific control measures need to be immediately instituted. If however, any one of the above is unknown, then the outbreak must be investigated to identify the specific cause. **The Rapid Response Team (RRT)** should be alerted and requested to investigate the outbreak. At the same time, general control measures should be instituted.

Step 2 – Sending the RRT

RRT members, with local health staff should initiate Medical, Epidemiological and Laboratory investigations simultaneously

A RRT should be immediately formed with those readily available. As stated above, it should have the minimum 4 categories of professionals. Resources (vehicles, drugs, reagents and forms) should be made available to the RRT and they should proceed to the location. At the location the RRT

members along with the local health staff should initiate a Medical / Epidemiological / Laboratory investigation simultaneously.

i. **Medical investigation –**
The physician / pediatrician will clinically examine the available cases (in the hospital or the community) and make a clinical diagnosis. The history will include questions that will identify the possible source, routes of transmission and contacts. He will also review the case management (as per the recommended protocol) and recommend suitable amendments to the therapy if required.

ii. **Laboratory investigation –**
The microbiologist will perform the appropriate lab investigations. He will advise on what samples are required, mode of collection and method of transportation and also to which lab it has to be sent. He will be responsible for the lab confirmation of the outbreak. If the outbreak warrants entomological investigation should also be done.

When there are many cases it is *not* necessary to collect specimens from all cases; just enough to confirm the diagnosis.

iii. **Epidemiological investigation –**
The epidemiologist will carry out a detailed epidemiological investigation that will look into the epidemiological and environmental aspects of the outbreak. The basic aim of the epidemiological investigation is to identify the source of the problem and the routes of transmission. For this he may ask for further tests like water analysis, entomological survey, etc.

iv. **Formulation of hypothesis-**
The RRT will then review all the various investigative findings and reports/results received and formulate a provisional hypothesis to explain the cause of the outbreak. This will answer the following questions:

- What was the causal agent
- What was the source of infection
- What was the transmission pattern
- Who are the people at risk

If this hypothesis fits with the facts, then specific response measures can be instituted. If however, the hypothesis does not fit with the facts, then further analytical investigation in terms of case control studies will need to be carried out. In the meantime, general control measures may be instituted.

v. **Specific response measures-**
Based on the above hypothesis, the RRT will recommend suitable control measures to be immediately implemented by the local PHC staff to curtail the

epidemic. If the team feels that the PHC staff needs any support, then they will request the District to provide the necessary help. Similarly if the district team needs support, then they need to call the State team.

vi. **Special studies if necessary-**
Following the institution of control measures, if the epidemic is under control and tapers off, the hypothesis of causation could be considered as correct. If the epidemic continues unabated then the Hypothesis would have to be reviewed. In such cases analytical studies like a case control study might have to be conducted to confirm the hypothesis. The decision to investigate further or to institute control measures are dependent on whether the source and the transmission are known or not.

vii. **Interim report**-
The RRT should file an interim report, giving details of the investigation and the diagnosis and also the control measures initiated.

viii. **Follow-up Visits –**
Once the outbreak is coming under control, the RRT can leave but should make follow up visits to ensure that the control measures are being implemented adequately. Also these follow up visits help to identify any new information that may have been missed in the first visit.

ETIOLOGY	SOURCE / TRANSMISSION	
	Known	**Unknown**
Known	Control +++ Investigate +	Control + Investigate +++
Unknown	Control +++ Investigate +++	Control + Investigate +++

Step 3: Monitoring the situation

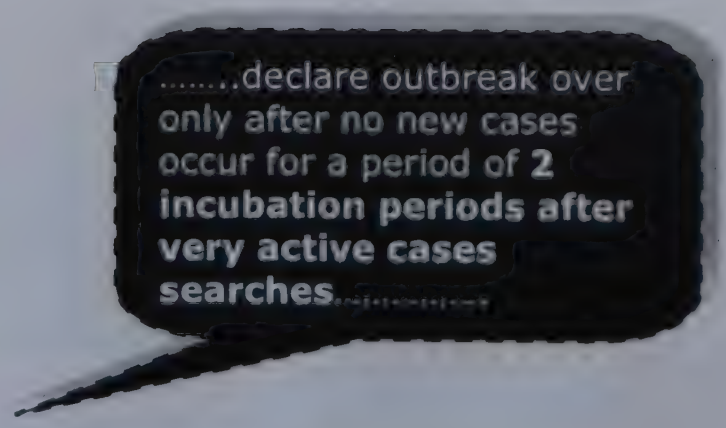
The DSO / MHO should monitor the situation on a regular basis. Ideally they should review the status on a daily basis and give feedback to the RRT as well as feed forward to the State. The main points to monitor are:

- The trends in the cases and deaths
- The containment measures that are being implemented
- Drugs / vaccine stock
- Logistic issues – communications, vehicles,
- Community involvement
- Media response

This should continue till the outbreak is officially declared to be over.

Step 4: Declaring the outbreak to be over

The DSO / DHO should declare the outbreak to be over only when there have been no new cases for a period of 2 incubation periods since the onset of the last case. This implies that a very active case search should continue during this period to ensure that cases are not missed.



Step 5: Review of the final report

The DSO / DHO should receive the final report from the PHC MO within 10 days of the outbreak being declared to be over. The Technical committee should review the report basically to understand why the outbreak occurred. Based on this review the Committee should make recommendations – immediate and medium term, so that similar outbreaks do not occur. Most important, they should try and identify deficiencies in the system that needs to be rectified.

Response to an outbreak

Even as the outbreak is detected, and is being investigated, control measures need to be instituted. These may be divided into Genral measures, Specific measures and Community involvement.

a) General measures:

- **Logistic support** to the field teams: This would start immediately when the outbreak is reported without waiting for verification, etc. The emphasis should be on saving lives.
- **Human resources:** Additional MO's, lab technicians and nursing staff (depending on the number of cases/deaths reported) may be sent from the block/ district hospital to strengthen in-patient treatment facilities in the nearest health facility, like the PHC. They will assist the MO health facility in providing emergency health care to the patients. Assistance from local practitioners/ specialists should also be sought for better on the spot management of cases. If situation demands 'camp hospitals' should be established in school buildings or similar structures.
- **Drugs:** In the event of an outbreak, there should be an uninterrupted flow of medicines to the area. Emergency medicine stocks should be mobilized and if necessary medicines should be relocated from unaffected regions for the use of the affected region.
- **Equipment and supplies:** this is also important and the district health manager should ensure that this takes place.
- **Vehicles and mobility:** this is of utmost importance as the teams need to move as fast as possible to the affected areas.

- **24-hour Communication channel**s: to be established between the District and the team leader at the outbreak location.
- **IEC** to sensitize the community about the problem, give them the correct messages and enroll their help in containing the outbreak.
- **Media:** This is an important task and needs the appointment of a special officer whose main responsibility is to update the press on a daily basis. This will reduce the stress for the district managers and will go a long way in communicating the right message to the community.

b) **Specific measures**; depending on the causative agent. The broad steps would include
   - Identification and nullification of the source of the outbreak e.g. chlorinating wells.
   - Minimizing transmission and so further exposure e.g. vector control
   - Protection of the host e.g. immunization or chemoprophylaxis.
   - Effective case management

c) **Community involvement-** while in the past managemnt of epidemics and outbreaks was primarily seen as a "top down" expert driven public health activity, it is now well established through public health practice that the involvement of the community should be a significant part of the whole epidemic/outbreak management strategy. This would mean involvement of community proactively by the district health team, at every stage of the operation, especially:
   - Identifying the cases
   - Encouraging active reporting of the cases
   - Supporting investigation
   - Supporing preemptive measures
   - Supporting epidemic measures
   - Involvemnt of community leadership, members and other reresentatives in decision making
   - Communicating data and analysis
   - Sharing the community experience with other communities after the events.

Reports

It is important for the concerned officials to make appropriate and timely reports to higher authorities. This has two main uses

1. It keep the authorities at the higher level informed so that they can make the appropriate decisions
2. It helps to review the outbreak and response, identify system failures and take corrective measures so that similar events are not repeated.

Thus reports are an important learning tool and should not be seen as a mindless chore. But for this to happen, the authorities at the appropriate level should read the reports and take the necessary action.

a) **Daily situation updates:**

During the period of the outbreak the nodal MO should continue to give daily situation updates of the outbreak to the next level. This should continue even when the RRT has started its investigation and should include the list of new cases, lab results received, any new findings, any containment measures taken etc. This daily report should continue till the end of the outbreak (i.e. no suspect case during a period which is double the incubation period). However it is important that these updates are kept as simple as possible – thereby sparing the MO unnecessary work.

b) **Interim report by RRT:**

The RRT will submit an interim report within one week of starting their investigation, response and control activities. The report should cover verification of the outbreak, total number of affected cases/ deaths, time, person, place analysis, management of the patients, likely suspected source, immediate control measures implemented, etc. The report will include reports by the physician and microbiologist, and entomologist (where applicable). The lab results received during that period, environmental factors, etc. It will also have a provisional hypothesis of the causation of the outbreak and comments/recommendations, if any, including whether any further outside help is necessary.

c) **Final report:**

Within 10 days after the outbreak has ceased, a final outbreak investigation report must be submitted by the local health authorities. This report must be comprehensive and give a complete picture of the multi-factorial causes of the outbreak, the precipitating factors, the evolution of the epidemic, description of the persons affected, time trends, areas affected and direction of spread of the epidemic. It should have complete details of lab results including regional lab (cross verification and strain identification), confirmation of the provisional diagnosis and other relevant information.

It is important that feedback from the report is shared with the lower levels and also other districts. Publication in a journal will ensure wider circulation of the lessons learnt.

d) **Summary of outbreak investigation/control at district level**

Surveillance has no meaning if there is no action taken. And RRTs play an important role in completing the surveillance cycle – using information for action. A rapid response to an outbreak not only ensures effectiveness of a surveillance system and prevents morbidity and mortality form a disease or a health related event. Response has two objectives, one is to contain the outbreak, while the other is identify problems with the health systems so that repetitions of the outbreaks do not occur.

There are certain principles of outbreak response that is common to most outbreaks and if applied will be effective in most situation

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District based public health management

Management is a part of daily activities of every kind of organization.

All management actions depend upon the objectives intended to achieve, and the objectives must therefore be clear. All other aspects of management must be seen in relation to the objectives.

Performance of daily activities require many elements- people, time, equipment, material drug etc- are brought together to achieve an objective to carry out the work.

The successful performance of activities and the achievements of objectives depend upon the application of knowledge and skills to problem solving, using all the resources in a most efficient way. Efficiency depends upon how these different elements are managed. In terms of Management concepts, limitations of this sort will prevent full attainment of the objectives. Proper attention to such details will ensure that, when knowledge and skills are applied to a problem, resources that function will support them and a system or organization that enables to run smoothly.

9. How to manage health programmes?

The most important core management challenge of District level Public Health Managers is the organization and implementation of various health programmes at district, sub district and community level – converting each objective or function of the District health system into one or more such programme initiatives. With many such health programmes being operationalized simultaneously throughout the year, the management challenge is do it with the core competence of integration, convergence and a commitment to complementarity . Some general principles are outlined here to ensure that managing programmes is a planned , rational, evidence based activity which is constantly monitored and reviewed so that it become a constant learning activity and improves the District Public Sector Health System.

The Whole Picture: Clarity of Levels /Sectors:

It is useful for all managers to

- have a certain clarity of the levels of the health system: District, Sub district, community centre and community /family level.
- to have an understanding of the nature of the programe activity: whether primary, secondary and tertiary level .
- to have a clarity on whether the program component is – promotive, preventive, curative or rehabilitative in its orientation.

A diagrammatic /tabular frame work of all these levels and activities will assist the manager in giving equal and relevant importance to all levels, nature and orientation and to be able to see it as a collective whole and not as vertical, compartmentalized and competing activities or programme components.

The main challenges in managing programmes included in this chapter are

- Participatory management
- Induction training and continuing education
- Time management and scheduling of activities
- controlling and maintaining work standards
- Supportive supervision
- Team building and health team approach
- Strategies for strengthening /extending the team
- Managing paper work- reports and records
- Staff assessment and feed back

Participatory management:

As a general trend all over the world good management practice is becoming more and more democratic , consultative, interactive and participatory to enhance the motivation, morale, and involvement of all members of the health team. Since health teams have to primarily build 'well being' in the community at physical, mental and social level, it is seen as being a rational assumption that team members experiencing healthy work relations and an ethos of well being at team and institution level that nurtures creativity and skill development and rewards performance, participation and enthusiastic involvement, will share the same ethos and framework in their interactions and relationships with subordinates and members of the community, patients and consumers that they come in contact with in their work. This spread effect is now accepted as good policy practice and is being encouraged more and more. Participation is a philosophical principle; an attitude of mind; and a developed skill and capacity. It needs time environment and encouragement to be put into practice. Public health managers can teach this and promote it best by being role models in participation.

Induction Training and Continuing Education

It is good management practice to ensure that all staff appointed to different levels of the system are always provided continuous training and educational inputs to maintain technical quality and standards of skill especially since public health systems call for a high degree of capacity and competence

a) An induction training is a very good way of preparing the new recruits for the challenges of any job. This is also the occasion to introduce selected recruits to institutional norms, goals, vision, mission, standards of work and encourage them to take a more informed and evidence based attitude to their jobs.

b) All systems should have a system of both informal and formal in-service training which is skill and capacity development oriented . It encourages and enables team members to upgrades their knowledge and skills on a continuous and often yearly basis.

c) Continuing education which may often be different from inservice training are modules offered by professional associations or training institutions or even organized specially by the health ministry to upgrade professional knowledge and skills every 3-5 years since technical knowledge advance at a terrific pace due to research and development. Incentives for CME are necessary. In many countries these are becoming mandetory to maintain the professional certification standards

The training ethos in a public health system should also be geared to identifying those candidates who show lot of promise and initiative and could be selected and deputed for higher levels of training which would benefit both their career development and the systems own capacitation by better developed utilization of members

Time Mangement- scheduling of activities

This section aims to promote the rational use of work time, through planning time according to the work to be carried out, arranging the timetables and schedule with the principle that using time efficiently is a management skill.

A district level manager will have his or her own method of managing time which he or she would have built through experience

Sometimes it is useful to know what proportions of time are spent on certain activities. The proportion of time spent on health work each month and other activities can be shown on a diagram

Planning Time Arrangement,

Any events planned or arranged at district level on daily, weekly, monthly or yearly time depending on the frequencies and regularity should be included in a time plan. Time plans can be written as schedules, rosters and timetables.

Time plans in a health Services should include,

- A timetable indicative of staff meeting or similar such events
- Schedule showing visits
- Duty rosters depicting the details and break up of duties of different staff
- Programme of any special health activity – like immunization schedule, nutrition campaign etc
- These can be developed as weekly monthly and annual overviews according to requirments.

Controlling and maintaining work standards

All management and implementation of work programmes must be controlled and supervised by some mechanisms that are inbuilt in to the management process to ensure

- That the work action is performed according to the same standard or set objective

- That the superviser or manager can determine any deficiencies / lacunae in the work to arrange for appropriate support and improvement
- To recognise good quality work and to recognise or endorse it
- To ensure that resources being invested are properly and efficiently used
- Identify staff that need further training and those who need more advanced training or promotions
- Identify common errors or defficiencies that can be addressed by additional in built mechanisms of safety /communication and additional trainings

All mechanisms introduced into the public health management system must have atleast the following four features:

- **Timely** – control measures should be taken or are in operation at the right time
- **Simple-** they should be simple and easily followed and help to produce the intended effect or result
- **Flexible-** they should be open to feed back and not be too rigid
- **Effective-** They should be reasonable but not so casual that they can be ignored – in which case they will be self defeating.

Some of the control mechanisms intordued in public health systems are

- **Job descriptions** – descriptions of job or instructions for the action operation can be provided on simple checklist or guideline style so that all team memebers have ready access to them and use them to do this work
- **Work schedules** – The manager can outline the work to be done in the form of a predetermined or pre planed work schedule that provides a date, time and content frame work for the work and or operation or programme . This is helpful both for systems, the team memebers and also the supervisor / facilitator
- **Supportive supervision** – this should be regular and ongoing and problem solving in its orientation. It can be planned or unplanned but the supervisor and supervised should take the opportunity of supervision to learn together.
- **Assessing the work performance-** workers and supervisors should be encouraged to assess the work performance with every team member on a regular annual basis and this can be through a self administred checklist and or other methods, introduced by the superviser. All work deficiencies found by the assessment must be responded to, by providing guidance counselling and sometimes further training to address the defficiency.
- **Diary and reports-** Each member shoud be encouraged to maintain a work diary and write brief, regular reports that identify the

strengths, weaknesses, opportunities and threats of each event or activity. If some feed back or dialogue takes place between the team members and their supervisor on these reports then the process can also be good for inhouse training and staff dvelopment.

Supportive supervision

Supervision is a very important part of workforce management and the main objective is to ensure that workers can always get help when they need it and that high standards are maintained by constant support of seniors who train, help and troubleshoot and problem solve for their juniors or those whom they supervise

a) Supervision ideally must be a supportive problem solving exercise when the superviser and those supervised can assess the work done and review how to do it better.

b) It should not be a fault finding exercise or the superviser checking on the supervised as if it is a 'law and order' or policing problem.

c) Supervisers can be autocratic ('Do what I say' attitude) or anarchic (Do what you like attitude) or democratic (Let us consult, discuss and decide what to do attitude).

d) Autocratic supervision is sometimes acceptable if the task needs consistency and strict coordination; or the tasks are governed by strict policies; or the people who are doing the task have little understanding or limited skills or are even somewhat unreliable.

e) Democratic or consultative supervision is always the best alternative, especially with people who are creative, take responsibility, are reliable, are competent and experienced.

f) Anarchic supervision is not supervision at all and can often lead to system faliure or system breakdown.

g) Supervision is most effective if the superviser has done the job of the supervised himself or herself earlier in the career or has practical knowledge and skill that can be shared with those supervised to enhance their knowledge and skill through example.

h) A good superviser teaches by role model and also always ensures that the process of supervision is a joint learning exercise and a mutually supportive dialogue.

i) Good supervision must always motivate people to grow, be more creative, show more initiative and take more responsibility in their work.

Team building and health team approach

A good public health manager is always also a good team builder because without a health team approach public health challenges cannot be addressed affectively.

There are many important factors and features, which can help to build a good team. These include the following .

a) A clear purpose and a shared vision or sense of common task to which every team member is committed.

b) Each team member understands his or her own role and place in the team.

c) Everyone understand the role of everyone else and respects and trusts that role as equally important.

d) There is flexibility in roles with team members willing to play each others roles if the need arises.

e) There is constant learning and training within the team.

f) There is a good leadership which respects and trusts everyone and whom everyone can trust and respect as well.

g) There is a stability and continuity in a team even if there is some expected turnover.

h) There are well planned working methods, procedures and resource which are known to everyone and practiced by everyone.

i) The relationships between team members is good even beyond age, experience, and skill differences.

j) There is a sense of loyalty to belonging to the team – a sense of common identification and collective achievement.

A good team leader or team builder is one who will provide time and space for all these factors to grow and develop gradually within the working relationships of the teams members.

Strategies for strengthening /extending the team:

One of the most daunting challenge for a district public health manager is to find adequate humanresource for every activity and programme at the district level. In public health work there are special events and campaigns that need large number of additional team members or volunteers. Strategies to extend the team on a regular or episodic basis are therefore important to meet the district health challenge. Many strategies have been used in the past and many new ones and are evolving and are being tested out all the time. Some of these are :

Delegation:

This has been defined as 'investing subordinates with authority to perform the managers job on the managers behalf' Not all the jobs can be easily delegated because many need skill and experiences and wisdom to make judgements. However in every managers/supervisors job at every level there are always some elements that can be delegated with standardized instructions and proper communication and supportive training when required.

Delegation has many advantages:

- Time can be saved for other more important duties
- Delays can be reduced in some decisions making
- Sometimes in health work, subordinates are spread over an area and reaching them to supervise or support them with certain decisions takes time. If standardized orders are used to delegate authority to these subordinate a lot of work can be undertaken more efficiently.
- A manager who delegates responsibility helps to prepare people for better skill development and this itself a method of in-service supervisory training.

The disadvantages are also to be kept in mind.

- Too much may be delegated and the manager may be seen as shirking responsibility
- Wrong decisions made by those to whom work has been delegated may cause delays, embarrassment or work may be done less well.
- People to whom work is delegated may have inadequate experience. Delegation is a very effective management tool but should be constantly reviewed and evaluated. It does not reduce the managers responsibility and delegated does not mean forgotton!

Community Level Volunteers:

At the community level the work can be extended by mobilizing, orienting and training community level volunteers who are the best selected by the community itself. Depending on the quality of training and especially with the use of 'adult learning' methods many simple

skills and activities that can greatly enhance output, outreach and impact can be transferred to the community, building community capacity and autonomy which is good for the success of health programmes.

Task shifting:

This is a new term which covers all efforts to transfer skills and tasks from one level of expertise/ competence in the health system to the lower level through a planned process of training and skill development. Experiments with the range of health and medical skills transferred to a wide variety of village/community based health workers and volunteers and auxiliaries are the best example of task shifting. Task shifting is more than delegation and requires a careful effort in planning, implementation and monitoring/supervision and evaluation. It can be done at different levels and the concept of a physician assistant, nurse practitioners and community health assistants are all examples of this process.

Involvement of other disciplines:

The increasing efforts all over the world including in the region to facilitate public health skills and capacity development in people from a wide variety of other disciplines is a move in the right direction so that public health managers can be trained with backgrounds in nursing, pharmacy, dentistry, social work, social sciences, management, law and a range of other newer disciplines. While medical professionals have often continued to dominate the public health scene and inadvertentally maintained the more restricted bio-medical and techno-managerial orientation in public health, this growing shift of widening the pool of public health managers and the effort to strengthen public health capacity building to a wider group of district and sub-district level functionaries is a very welcome policy innovation.

Managing paper work- Reports and Records

All good management systems always have a system of records and registers to minatain and monitor information about the work done.They also have a system of reporting that ensures that each action/event /programme gets reviewed by the team members, and becomes a part of the historical narrative of that systems. Generally it is a good idea to highlight action points and responsibilty. A good meeting also becomes the basis for learning together and can be an effective tool for efficient supervision, monitoring and evaluation. It is important to ensure and facilitate that recording and reporting is

- Accurate
- Accessible
- Available when needed

- Analysed for trends and learning
- Utilised for system improvement

Registers should be well planned and thoughtfully evolved to reduce the burden of too much, too repetetive, and unimportant work expanding content.

All records and reports should also be used by team members themselves to assess their own performance and support their own planning, learning, implementing and monitoring. It has been found that the more the keepers of registers uses the information for their own purposes, the better the quality and content of the recorded information. Records kept for someone-else, a higher authority or a supervisor or some distant organisation, also leads to greater sense of anonimity and this effects quality and reliability of the recorded information.

Reports should also be brief, to the point and convenient for review and dialogue. Writers of reports should be encouraged to be analytical and critical so that the system can learn from each report and identify lacunae or defficiencies for further quality improvement.

Reports that are commented upon by supervisors, help to strengthen morale and also enhance quality of reporting.

From time to time these records should be analysed and edited for public distribution so that it becomes a learning expereince for every one. Such regualar compilation and distribution of reports are good for the system and contribute to team morale.

Staff assessment and feedback

Regular assessment of performance of all levels of public health team members is good for the quality control and morale of both the individual and the public health system.

a) Every individual team member would benefit from an annual performance assessment made by a designated senior or supervisor.
b) This assessment should cover work output, skill development, team relationships and identify strengths to be encouraged and weaknesses to be addressed.
c) As a measure of accountability and transparency this assessment should be shared with the person concerned and be subjected to dialogue and approval. If it is made a 'learning opportunity' rather than a 'top down judgment' or punitive occasion it works well for both the individual and the system.

d) Checklists provided to the assessor help to make the process more evidence based and objective, preventing subjective factors such as bias or prejudice creeping in.
e) When work deficiencies are recorded these should be followed up by suggestions of how to improve performances and creating of options or opportunities to get counselling, orientations or other useful advice to ameliorate the deficiency.
f) While staff assessement is a good tool for career development taken together as a system building exercise it can also help to strengthen the system at all levels including technically and from the point of individual and team morale.
g) Poor assessment can also point to system failure – failure of supervision, delegation or in service training and so performance assessment should be taken as a key method for individual growth but also as a key method of system assessement.
h) The biggest challenge is to place performance assessement as a positive system building exercise and not reduce it to a 'policing exercise' with warnings and judgements that reduce self esteem in particular and group morale in general.

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10.How to manage human resources?

One of the biggest and often the most challenging task of the District Public Health Management is the management of the human resources. This is a large multi-level, multi disciplinary and multi skilled team under his/her charge. The success or reputation of the manager often also hinges on the ability to make such a diverse team committed to a common goal, vision and mission and the plural challenges of health, health care and health systems at the district level.

Health Human-resource management consists of several important facets. These include –

- Human Resource Planning
- Recruitment and Selection
- Salaries, compensation and allowances (Most often these are set by State authorities, what District level planning requires is the selection of grades for any new staff envisaged)
- Allocation of work, deployment including postings and transfers
- Career planning and staff development
- Discipline and grievance redressal and incentives and rewards.
- Counseling and guidance
- Conflict resolution
- Job descriptions – norms and standards

Human Resource Planning

Most often the District Health Manager will find himself/herself thrust into a position of management and leadership by a sudden promotion, with or without any special training. Often the biggest and toughest challenge will be the army of health workers – from doctors to village based cadres, who are to be managed to meet the district health challenges. However whether as hindsight or as prospective planning, every District manager should be encouraged to undertake a human resource planning exercise. It is also a good idea to repeat this exercise periodically, say every 2 to 3 years. Planning for human resources should include the following steps:-

a) Assessing how many personnel of specific types and skills are needed for the different facilities existing in the district and at different levels (while this will often coincide with the number of posts sanctioned for facility and every level, the assessment must also be done with an appreciation of actual need so that new posts or additional human resource needs can be facilitated (or excessive staff redeployed)

b) Identifying in this assessed need the possitions available, filled and correctly deployed. Vacant positions must be highlighted with a note on the current status of attempts to fill the posts.
c) From these two steps an assessment of how many are needed can be made and a plan drawn up to recruit, and or train to build up these numbers / types of personnel required

d) The next decision is to decide through consultation with the district health team how many can be recruited by open selection and how many should be produced by inservice training and upgradation.

a. Many cadres like multipurpose workers are also produced in different countries by special institutions which provide specific pre-service education: e.g. schools for auxiliary nurse mid wives etc.,

e) As this plan is evolved it is advisable to also plan for the foreseeable future and decide how many posts or personnel would be required in the next 5-10 years. Plans are not static and a dynamic plan providing for future growth and expansion in the quantity and quality of the health services is always preferable.

f) From all these suggested steps a district health human resource plan can be evolved, and updated and reviewed for need and performance from time to time.

Recruitment and Selection

Recruitment of appropriate staff for the District health system is the next challenge. This is usually done in most countries by some sort of public recruitment commission and may even be centralized with the District Health Officer not having a direct say in the selection process.

The challenge of the recruitment process is

a) To keep it fair and transparent
b) Ensuring maximum weightage on objective criteria
c) To have a clarity on the type of requirements for each job – or each team member.

This usually includes

- Attainments (including qualifications and experience)
- Special aptitudes
- Interests
- Disposition or personal style / attitudes e.g assertive, confident, ability to influence others
- Circumstances including social needs

d) Having a plan for the selection process with some of the factors above help to make it more objective and less subjective or adhoc

e) It is advisable to have more than one member in the selection process and for each members to independantly evaluate or assess the same issues / features in all the candidates to introduce in element of standardization.

f) Recruitment depends on the salary and compensation package. If it is good it will attract more candidates and a better range is available for selection

g) The selection process must also often try to determine candidates for difficult terrains and difficult or challenging aspects of a job

h) For the more specialized jobs or often for jobs at a higher level – the trend is to appoint a search committee or some times even a recruitment agency which is provided with set criteria and standards / norms for the process

i) All selection processes must have a method to screen a large number of applicants to produce a shorter list with those having reached an acceptable basic standard through a written examination and or basic verification of certification and skills. An interview procedure helps to arrive at a suitable candidate from the short list

j) It is good policy to have a back-up list of selected candidates in order of performance because often the candidate selected does not report for duty. It is efficient in terms of time and effort, as well as being fair to candidates who may have done well in the selection process but lost out to another candidate.

k) Finally in many public sector health system for the purpose of quicker recruitment and filing up urgent shortages in less a time, recourse to contract appointments is being made. These appointments can be more decentralized and can be more flexible and innovative include in arriving at compensation package. However there is some problem of these not being very good for job security and long term motivation of staff. The absence of social security in contract jobs is also a cause for concern.

l) Taking the trouble to select proper workers with requisite qualification and experiences for a job can avoid a lot of problems later with reference to job satisfaction, job performance and staff morale

m) Finally it is important in recruitment/selection procedures to give adequate weightage and focus to in-service candidates who may be promoted to next levels after adequate training and experience.

Salaries, Compensation and Allowance

A very important component of health human resource management is the economic incentive provided or linked to each job and this is an important factor for long term satisfaction, retention and sustainability of system building in any public health system. **(This important point is often not directly in the ambit of District Health Managers and may be considered / decided at State or Central levels. However district managers can provide feedback from their teams on these matters to encourage regular and responsive action)**.

a) Salaries must be commensurate with educational attainments and achievements and years of experience. Usually in most countries some nationally accepted scales and standards of pay are applied to public health system related jobs.

b) In addition to basic salaries, the compensation package usually includes other allowances like transport, rental, child allowance, dearness allowance and medical insurance.

c) Many public health systems offer additional incentives to compensate for the staff having to work in difficult or remote areas or in non- urban situations. These include hardship allowance, additional duty allowance, books and scholarship allowances, support for conferences and studies – short term and long term, support to childrens education especially when adequate facilities are available only away from places of work.

d) Social security schemes like health and accident insurance, gratuity and provident fund and pension plans help to provide long term job security and better staff morale.

e) Finally it is important to review salaries and compensation packages every 3-5 years to ensure that rising costs of living do not affect morale or reduce motivation.

Deployment, Posting, Transfers and Promotions

A good human resource development strategy is greatly strengthened by a systematic and regular method of rational deployment of team member to levels and situations depending on need, load and demand. Giving workers task which are within their capabilities and make the best use of their skills and knowledge is a challenge. (It is an unfortunate fact that very often

transfers and postings are carried out for reasons other than job requirements and may not be left to the District Health Manager)

a) The biggest challenge for rational deployment is the adage – fitting the right person intor the right job.

b) Every person must be oriented and supported to understand and perform his/her roles according to the requirements of the job and the vision of the system..

c) Postings according to situation may be difficult or challenging or moderately so or relatively easy. It is a good policy to rotate these postings between candidates so that no one is discriminated against.

d) Transfers from one place to another on the same job or from one job to another should always be fair, transparent and non discriminatory.

e) Promotions from one level to the next should be based on experience, aptitude, getting the necessary qualifications for the next level job and based on performance assessment.

f) Adhoc, arbitrary or politically motivated transfer , postings or promotions should be avoided to present staff dissatisfaction, loss of morale and demotivation.

g) Posting, transferring or even promoting candidates to jobs where they cannot use their skills or experience can be very demotivating and demoralising.

h) All postings, transfers or promotion policies should be based on rational criteria which take into account the suitability of candidates for a job; and the needs of the public health system itself

Career planning and staff development

A good health human resource development plan will always include a strong element of career planning and staff development.

a) All staff should be provided with opportunities to discuss their career plans and identify options and alternatives for self development – especially technical advancement with a focus on skill and capacity improvement.

b) Apart from couselling on this aspect, public health system management policies should be flexible enough to allow staff to avail of special study leave or allowances and opportunities that can promote technical advancement.

c) The health human resource plan should allow for a career structure and advancemnt of staff alone well degisgnated and delinated a career pathways or career ladders.

d) Staff should be encouraged to make use of these options and opportunities and not allowed to stagnate at one level. This is particularly important for long term staff morale and social justice.

e) Women candidates must be supported by gender sensitive staff and career policies that allow them time, space and opportunity for child bearing, child caring and for mid course breaks for family duties – often imposed by their social roles in society.

f) While it is important to constantly find ways and means to keep up the motivation and morale of staff, all good public health managers must also be ready to discover staff who have outgrown their work level and require new jobs or enhanced opportunities to maintain their professional standards or creativity. Some of them may have to be coouncelled to change their current positions and seek career advancement by changing employers or seeking more relevant job opportunities commensurate with their needs and evolving potential.

Discipline and Grievance Redressal

Good workforce management is often misunderstood as strict disciplinary enforcement and it is often thought that if strong action is taken against a person (who may often even made a scapegoat) and made to take full responsibility for a system failure then the system will be set right. Fear and stern disciplinary action are overated as determinants of change.

a) As a guideline all systems should recognize that most members of a team usually work properly within certain limits and follow rules and regulations in a disciplined way.

b) A few people, often in the minority, break rules and regulations or perform in ways that may be difficult, awkward, embarrassing or deleterious to the management of the system. Such errant members of a health system need some form of action that will encourage them to become part of normative behaviour.

c) All such disciplinary issues should always be properly, promptly and appropriately investigated and action taken must then be justified, within acceptable limits and primarily to act as a deterrent to further rule breaking and a motivation to return to normative behaviour.

d) Sometimes disciplinary action should be supplemented by some generic system change and also some positive incentives to solve the primary problem or reduce it to manageable proportion.

e) Disciplinary action should never be adhoc, anarchic or involve breaking of rules themselves.

f) Before any disciplinary action is taken, the person accused of indiscipline must have recourse to a mechanism of grievance redressal that is available for consultation and review by all concerned. This is particularly important to prevent any wrong accusations, or biased action by supervisers or seniors, or malicious action by co-workers.

g) As a counter to indiscipline many well managed health systems offer rewards and incentives 9including recognition) for good performance or good quality work to motivate the hard working, rule abiding and sincere worker and to encourage them to continue to demonstrate efficiency and reliability in their performance

h) These incentives for good performances do not always need to be monetary or financial incentives. They could include support to a training programme or continuing education seminar, or some form of social or public recognition (like best / sincere worker award etc) or some leave relaxation or some additional responsibility or work opportunity.

Job descriptions: Norms and standards:

One of the key challenges in public health management is the constantly changing and dynamic nature of health programme responses to a changing health scenario. Roles and responsibilities of staff are also constantly expanding or getting modified in nature and methodology.

Good district level public health management systems are greatly supported if they build job descriptions for all levels of jobs with clarity and comprehensive detail and also set norms and standards for performance at every level. This is an evolving exercise which should be regularly reviewed and renewed with feedback from supervisors and workers and dialogue with technical resource persons who may undertake operational research or pilot projects to evolve these job descriptions – norms and standards.

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11. How to organise materials management: Drugs, equipment and facilities

Drug Supply (medicines) and Logistics [1&2]

Drugs – estimates and supplies

Drugs or medicines are those that satisfy the health care needs of the majority of the population and they should, therefore, be available at all times in adequate amounts and in the required dosage forms. Drugs are a special resource that needs to be managed carefully. When drugs are out of stock patients are unlikely to visit health facilities, not even for preventive advice. All drugs can expire while some drugs (for instance vaccines) need special transport and storage conditions. Furthermore, drugs are much-wanted items that are sometimes misused or stolen. Anyone in the health service, including pharmacists, planners, storekeepers, prescribers, nurses and accountants, have to do with drugs or drug supply in one way or another. Therefore, the district health manager should follow the following four steps for effective drug management

A drug suppy system

1. **The components of drug system**
2. **Calculating the drug requirements**
3. **Ordering the drugs;**
4. **proper management of the drug store.**

a) The components of drug system

- **Drug selection:** This considers issues of drugs in terms of the needs, requirements and the types as well as their costs. An essential drug list for different levels of health care, with in a district should be evolved, preferably with standard treatment guidelines.
- **Drug procurement:** When procuring drugs the health manager need to be conversant with the existing procurement system like the selective, open tender or direct procurement and have an evaluation system to guide on procurement procedures.
- **Drug distribution:** Under this component DHM (district health manager) need to be aware of the centralized, decentralized distribution systems. One way of keeping track of drug movements and supply position is to use tools such as stock cards and delivery forms.
- **Rational drug use:** Drugs should be selected, procured and dispensed in order to be correctly used. A correct diagnosis, rational prescribing, correct dispensing of drugs and good patient compliance lead to their appropriate use.

b) Calculating drug requirements

There are two main methods of estimating the requirement of drugs.

i. **The morbidity method:** which estimates the need for specific drugs based on the expected number of attendances, the incidence of common diseases and the standard treatment patterns for the diseases considered
ii. **The adjusted consumption method:** which starts from existing consumption of drugs concerned and then assumes that the same amount is needed this time. The adjusted quantities of drugs used per standard facility are converted into standard quantities per 1000 treatment episodes and these are then used to estimate the drug quantities required for each facility of the type being considered.

Example: If on average ten adults per day are treated for malaria and the standard treatment for malaria in an adult is a total of 10 tablets (of 150 mg chloroquine base), you need for a three-month (90 days) period:10 (patients) x 10 (tablets) x 90, that is 9000 tablets of chloroquine for a three month period, or nine bottles of 1000 tablets. The district may need additional chloroquine for the treatment of children and for prophylactic use. Ensure that a suitable buffer amount is included to cover possible requirements of outbreaks and delays in supply

c) Ordering the drugs;

i. In order to order and obtain drugs rationally standard and regularly updated drug lists should be prepared in accordance with standard treatment guidelines.
ii. Deciding between drugs to be included in the list. Generic drugs rather than brand drugs from an essential drug list should be preferred. In the absence of generic drugs approved brands through rate contract supplies should be included. When quotations are sought it is important to keep in mind quality and not only make decision on cost factors.
iii. The important questions to ask when working on a standard drug list are: What diseases and conditions are common in the district? What is the standard treatment for these diseases and conditions? Which drugs are available and affordable for these conditions? What is the effectiveness, convenience, toxicity and cost of these drugs?
iv. Follow the procurement guideline such as types of tendering and placing orders and keep in mind the time required to procure them.
v. Evaluate the technical requirement and price of drugs in an open and transparent manner

d) **Proper management of a drug store.**

i. Store drugs in an orderly manner and record them in a stock ledger or use computer programs.
ii. Drugs should be kept in a dry and cool and away from light.
iii. Ensure that the tablets are in airtight packing tins or jars if supplied in bulk and clearly labeled with the product name, strength and date of expiry.
iv. Strip packing and polythene packets are available today and greatly help efficient storage
v. When storing and using drugs, remember FIFO and FEFO principles:

FIFO = First In First Out (First Use The Drug That First Went In The Cupboard)
Medications That Were Procured Earlier Should Be Utilised Before Medications Procured Subsequently

FEFO = First Expire First Out (First Use The Drug That Will Expire First)

How to keep pulse on drug management at district level

- Have a stock control management system i.e stock books, order books, stock cards
- Follow minimum stock level by FIFO, FEFO when manual management is being followed. If the store management is computer based then an automatic warning system for replenishment of items can be generated if minmum stock levels are reached.
- Disposal of unused or date expired drugs; follow proper procedures at regular interval
- Promote ways and means to order and to prescribe generic drugs and promote rational use of medicines

Summary of drugs supply and management

(1) Define common diseases for Health Care Package for each district or area using the following criteria :
(2) Select the diseases using the following methods:
    i. Study of existing records at district level and below
    ii. Special survey reports if available
    iii. Study of infrastructure including manpower, institution
    iv. Study the delivery system
    v. Pattern of local administration and community system
(3) Estimate the drug requirements quantities required to be supplied at each level of the health care system.
(4) Ensure uninterrupted, adequate and timely supply of essential drugs, other equipment and supplies
    i. Strengthen procurement procedures for drug supply

ii. Remove bottlenecks in the procurement, storage and supply of drugs
iii. Ascertain drug needs for routine and complicated cases
iv. Train district level officers and staff in the management of drug supply
v. Send random samples of drugs for quality check up to approved laboratories
vi. Regularly inspect peripheries for availability of essential medicines:

Drug audit

Ensure that a system of drug audit is developed for the district through the District Health Authority/Committee: Analyze systematically quality drugs procured, distributed and their utility at regular interval. Always promote rational use of medicines.

Regular and constant drug supplies; good drug audit and; and constant monitoring of drug related problems including quality and resistance is crucial for the success of a good public health management system.

Drugs – estimates and supplies

(1) Define common disease for Health Care Package for each district or area using the following criteria :

(2) Select the diseases using the following methods:

i. Study of existing records at district level and below
ii. Special survey reports if available
iii. Study of infrastructure including manpower, institution
iv. Study the delivery system
v. Pattern of local administration and community system (select five to six common diseases)

(3) Estimate the drug requirements based on 1 & 2 and the quantities required to be supplied at each level of the health care system.

(4) Ensure uninterrupted, adequate and timely supply of essential drugs, other equipment and supplies

i. Strengthen procurement procedures for drug supply
ii. Remove bottlenecks in the procurement, storage and supply of drugs
iii. Ascertain drug needs for routine and complicated cases
iv. Train district level officers and staff in the management of drug supply
v. Send random samples of drugs for quality check up to approved laboratories
vi. Regularly inspect peripheries for availability of essential drugs

Managing of Equipments[1]

Equipments are things, tools or machines needed for a purpose or activity. All health systems require different types of equipments which need regular maintenance, repair and replacement.

This section provides a conceptual frame work to explain

- Procedures for management of equipment
- Maintaining an inventory
- Use of checklist for maintenance of equipment

Two main types of material equipment are known

- Expendable – which are used within a short time, eg syringes, lab stain, cotton etc
- Non expendable- which last for several years and needs care and maintenance, eg microscope, BP apparatus, weighing machine, furniture etc

The four main procedures used in the management of equipment are

- **Ordering**-ie obtaining the equipment from the shop, store etc
- **Storing**- ie recording, labeling, and holding equipment in a stock or store room
- **Issuing**- ie giving out recording issue, balance of remaining stock and receiving
- **Controlling** and Maintaining life- controlling expendable equipment maintain and repairing non-extendable equipment.

A good management takes care of the equipment by

- Instructing and motivating the staff to feel responsible for the equipment
- Ordering supplies when needed
- Storing supplies safely
- Controlling the use of supplies
- Ensuring routine maintenance of damage caused by normal use related wear and tear

Managing Facilities

A District Level Public Health Manager will have a large number of institutional facilities under his / her jurisdiction. This will include

- a District Public Health centre often separate from the district hospital
- a number of smaller sub-district hospitals in countries, where the district is a larger than average geographical entity;
- a number of health centres with varying numbers of sub-centres

- and a few other specialized or focused functional units including laboratories, stores, health education centres
- and offices for the district health team.

While management modules often focus on human resource management, materials management and financial management and also management of time, the challenge of 'facility management' is not often specifically outlined and most often just taken for granted.

While the maintenance and repair work of all the institutional facilities in a district may be supervised by the public works department and its maintenance unit, the district public health manger has certain important roles to play to ensure that these institutional facilities play their role in making patient care and community support relevant, quality conscious and efficient.

- **Mapping of service facilities**

  All these facilities should be marked for easy reference on a district map.

- **Regular maintenance and repairs**

  They should be assessed regularly by the public works department for maintenance, and repair of the basic civil works and electricity and plumbing and sewerage connections. A schedule for maintainanace and repair is on a continuous and ongoing basis together with cyclic attention to major maintenance –say once in 5-7 years should be drawn up and muticulosly followed.

- **Public Health facility standards**

  In many countries, public health standards and norms are being evolved for sub-centres, health centres, dispense areas, sub-district and district hospitals and the district manager must ensure that these standards and norms are maintained or the facilities are gradually upgraded to reach these norms.

- **Environmental friendly structures**

  The physical structures must be made more environmental friendly. With good supervision and regular dialogue with the public works department they can be made more healthy, eg.,

  - adequate water supply and sanitation facilities must be available and accessible for both staff and patient;
  - the buildings should be modified to prevent rain water stagnation and vector breeding due to inadequate architectural design
  - and with a little imagination and some additional investment can be geared to rain water harvesting that can be important in 'water shortage' situation.
  - Energy efficiency should be kept in mind

- **Nutrition / Dietetics components**

  The facilities depending on their size and the patient / community load they experience, should also have provision for hygienic snacks and or meals for staff and patients and whenever possible in larger institutions especially hospitals the services of a nutritionist / dietician should be available to supervise these aspects.

- **Codes of practice or healthy design / healthy procedures**

  New codes of practice are being evolved to ensure that hospitals and dispensaries are baby friendly, women friendly and disability friendly and it is important for the district manager to ensure that these norms are adhered to and facilities are so designed to make them acceptable in the context of these norms.

  Many of these norms are also symbols of healthy practices or health promoting environments so meeting these norms are also an integral part of health promotion and healthy advocacy. Patients and their families experience these healthy norms, facilities and designs and families and communities learn from these experiences directly and indirectly.

- **Staff Quarters**

  Staff quarters and residences and sometimes hostels for junior staff or field workers should also be included in the area of facility management. These facilities should also be well maintained, constantly reviewed and provided in adequate numbers to maintain staff morale and motivation.

- **Referral system complex**

  A very important management challenge especially in the context of continuum of care and the management of different levels of health problems at different levels of the district health system is the need for a *well developed and coordinated referral services system*. Patients and members of the community must be advised in an efficient way to seek the right type of service at the right type of level with the referrals being efficiently managed and communicated along the system.

- **Communication facilities**

  This referral system also calls for a coordinated health team for regular training programmes linked to various health programmes and also for continuing education and in-service training of staff and field workers. These facilities should be constantly reviewed, maintained and upgraded to meet the challenges of the training programme in terms of numbers and accessibility and supportive facilities and also in terms of updating in terms of communication facilities – including computer and digital technology and electronic projection facilities.

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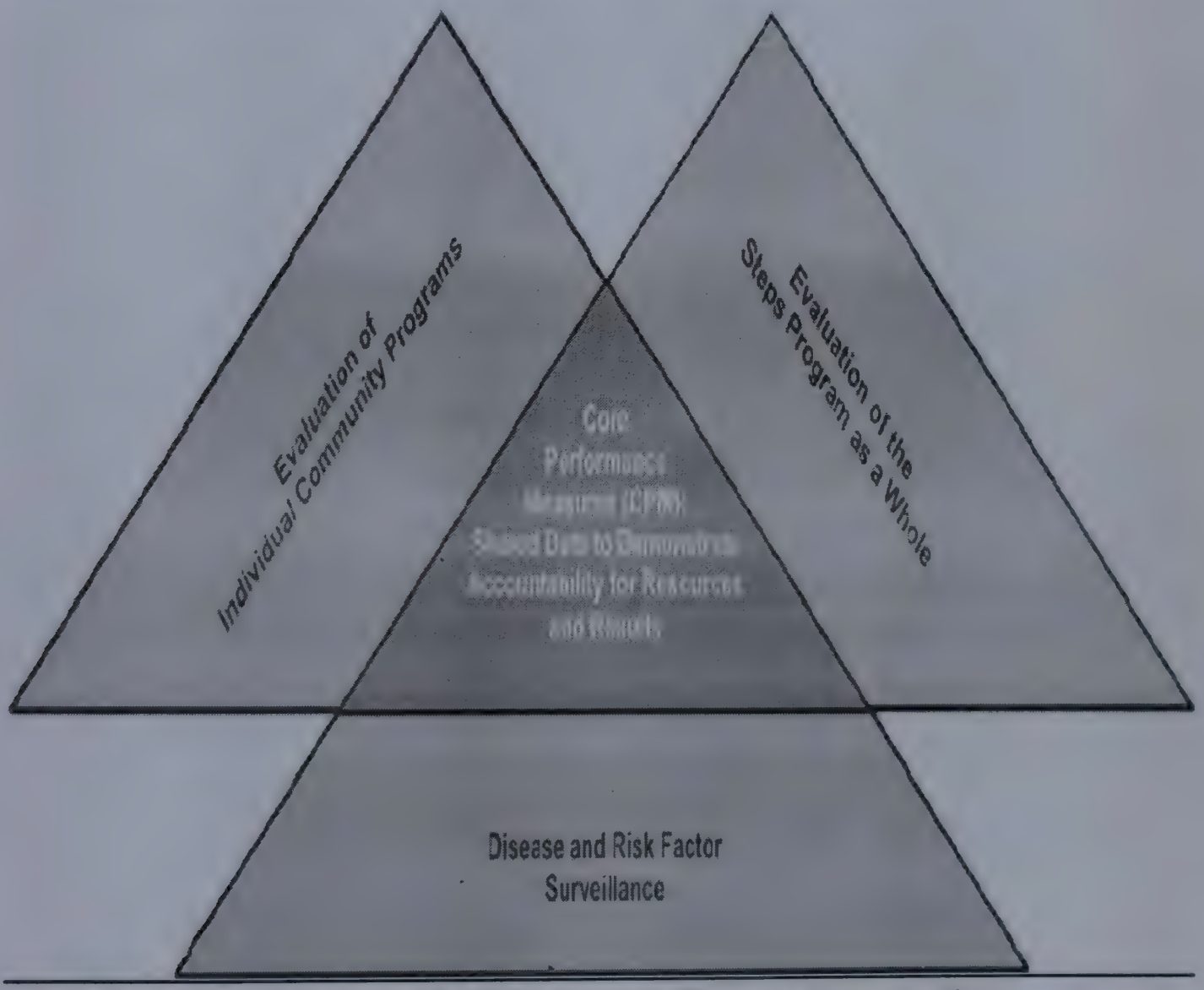
12.How to monitor and evaluate?

Why to monitor and evaluate?

Monitoring and evaluation enables the district health manager to check the community health status and its progress: It tries to know where are we by asking questions oneself such as "are we making a benefit to the community?" but "are we making a difference?" Through monitoring and evaluation, the district manger can:

- ✓ Review progress;
- ✓ Identify problems in planning and/or implementation;
- ✓ Make adjustments so that you are more likely to "make a difference".



The Intersection of Evaluation Activities across the Steps to a Program—Core Performance (Source:CDC, framework for program evaluation)

10.2 How to do -Monitoring and evaluation

Overview of the Framework for Program Evaluation

ELEMENTS OF THE FRAMEWORK

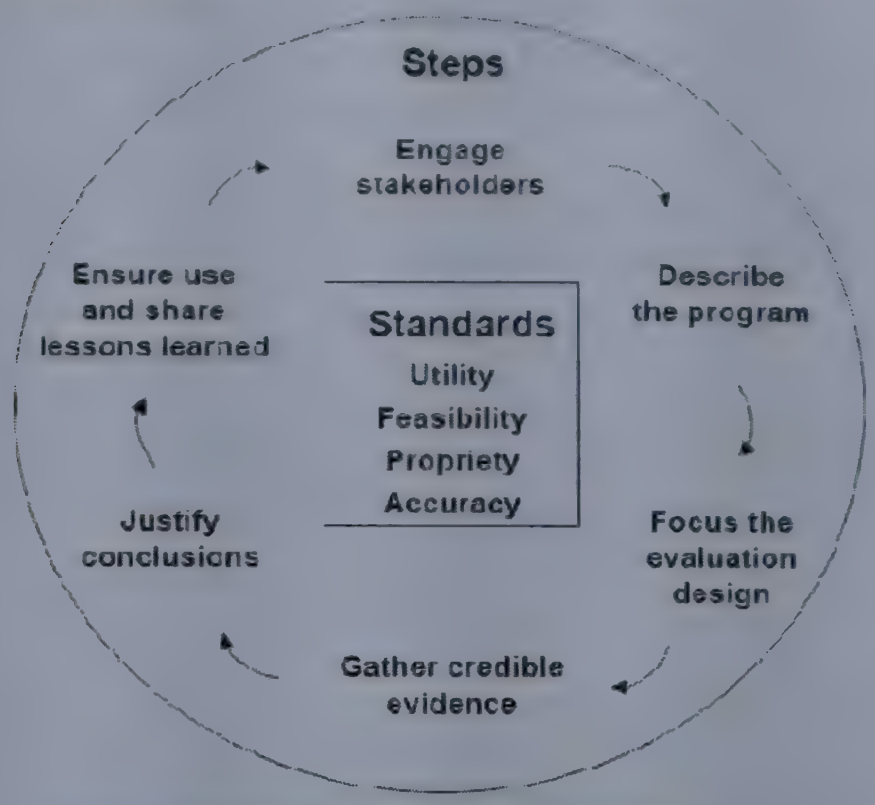


Figure: Showing different steps in evaluation
(Source: CDC, http://www.cdc.gov/TB/publications/newsletters/notes/TBN_2_08/images/framework.gif)

Monitoring involves:

- ✓ Establishing indicators of efficiency, effectiveness and impact;
- ✓ Setting up health systems to collect information relating to these indicators;
- ✓ Collecting and recording the information;
- ✓ Analysing the information;
- ✓ Using the information to inform day-to-day management.

Monitoring is an internal function in any health program or health service.

Evaluation involves

- Looking at what the health program intended to achieve – what difference did it want to make? What impact did it want to make?
- Assessing its progress towards what it wanted to achieve, its impact targets.
- Looking at the strategy of the project or organisation. Did it have a strategy? Was it effective in following its strategy? Did the strategy work? If not, why not?

Looking at how it worked. Was there an efficient use of resources? What were the opportunity costs of the way it chose to work? How sustainable is the way in which the health program works? What are the implications for the various stakeholders in the way the health programs being implemented ?

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13. Leadership and management for public health [1&2]

What is Leadership?

Leadership is a process or ability to influence the behaviour of others, to motivate and mobilize others to work together and achieve a common goal. It is a way of focusing and motivating a group of people to enable them to achieve their own aims and develop themselves. It also involves being accountable and responsible for the group as a whole.

Leadership is a function comprising of three factors: the leader, the group and the situations or conditions. Thus leadership is determined not only be the characteristics of the leader and the team but also by the situations that prevail in the programme or organization.

Leadership is defined as defined as "process of social influence in which one person can enlist the aid and support of others in the accomplishment of a common task" (Leadership, Wiki, 2009).

There are many definitions of leadership. However, one common theme that runs through each of them is the ability to inspire confidence and support among the members of a group to achieve the programme goals. "Defining leadership has been challenging. The following sections discuss several important aspects of leadership including a description of what leadership is and a description of several popular styles of leadership". The leadership is quite subjected to situational interaction, function, behavior, power, vision and values, charisma, and intelligence among others.

Leadership and Management

It is important to understand the difference between management and leadership. While management deals with the administrative aspects i.e. planning, organizing, monitoring, leadership deals with the interpersonal aspects of a managers' job i.e. inspiration, motivation and influence.

As a District Level Public Health Manager, you function both as a leader and a manager. The major responsibilities of a manager is to operate and maintain the organization efficiently, ensuring that it provides useful services to the community. Managers tend to be problem-solvers, seeking better ways to use their resources to get the job done. Effective managers bring order and consistency to programmes. Leaders, on the other hand, are pathfinders; they branch out more in their thinking. They are concerned with building the organization for the future, providing direction, securing new resources, developing new capacities, preparing the organization to meet challenges

and take advantage of emerging opportunities, adapting to change and networking.

Leader	Manager
Visionary: focuses on the future and plans long term; asks "why"	Planner, organizer, coordinator: focuses on systems and structures; deals with short term and day-to-day issues; asks "how" and "when"
Strategist: pathfinder; sees ways to achieve goals; provides direction	Monitor: ensures that activities are implemented to standards
Policy-Maker Campaigner: promoter; activist; public relations; identifies new resources	Supervisor: directs; trains; solves problems
Team builder: empowers people; offers support; inspires trust	Efficient user of resources
Change agent: seeks out emerging opportunities; is prepared for change	Status-quoist (traditionalist); concerned with stability, continuity
Do the Right Thing	Do Things the Right way

Source: Leadership and Strategic Management for TB Managers, Module-3, WHOSEARO-2008.

Qualities of both a manager and a leader are necessary. While performing managerial or administrative roles i.e. planning, organizing and controlling, managers are often called upon to take up leadership roles that deal with the interpersonal aspects of a manager's job, i.e. inspiration, motivation and influence which may have a long-lasting impact on individuals and the group. A manager without leadership skills is an administrator, and a creative, far-sighted leader who is unable to implement a vision (i.e. without managerial skills) will confuse and lose the team.

While there may be only one or two designated leaders in an organization, such as the programme director or team leader, leadership qualities can be found in many others within the team.

Leadership styles

"Leadership style" is the style one uses as a leader to influence the behaviour of others. Leadership styles tend to vary considerably from situation to situation and it is not helpful to think of leadership styles as an either/or option. While the behaviour of some leaders is characterized mainly as directing their team activities in terms of task accomplishment (directive behaviour), other leaders concentrate on providing socio-emotional support and on building personal relations with their teams (supportive behaviour). In other situations, various combinations of directive and supportive behaviour were evident. Effective leadership calls for a greater understanding of people

and situations, as well as the ability to use the appropriate leadership style in a given situation.

Directive behaviour:

A leader engages in one-way communication; spells out the groups' roles, and tells the group members what to do, where to do it, when to do it, how to do it and then closely supervises the performance. Three words can be used to define directive behaviour: 'structures, controls and supervises'.

Supportive behaviour:

A leader engages in two-way communication; listens, provides support and encouragement, facilitates interaction, and involves the group in decision-making. Three words can be used to describe supportive behaviour: 'praises, listens and facilitates'. The emphasis on these behaviours can be high or low. The four quadrants of a situational model represent different leadership styles as follows: -

Table 2: The four Basic Styles of leadership

High

↑

Suporrtive Behaviour

↓

Low

High Supportive Low Directive Behaviour S3	**High Directive High Supportive Behaviour S2**
Low Supportive Low Directive Behaviour S4	**High Directive Low Supportive Behaviour S1**

Low ← Directive Behaviour → High

Source: Leadership and Strategic Management for TB Managers, Module-3, WHOSEARO-2008

a) **High directive/low supportive leader behaviour (S1)**

This is referred to as the ***directive style of leadership***. The leader defines the roles of members of a group and tells them what task to do and how, when, and where to do it. The leader alone initiates problem- solving and decision-making. Solutions and decisions are announced; communication is largely one-way, and the leader closely supervises implementation.

b) **High directive/high supportive behaviour (S2)**

This is referred to as the ***coaching style of leadership***. The leader still provides a great deal of direction and leads with his or her ideas, but the leader also attempts to hear the group's feelings about decisions as well as their ideas and suggestions. While two-way communication and support are increased, control over decision-making remains with the leader.

c) **High supportive/low directive leader behaviour (S3)**

This is referred to as the ***supportive style of leadership***. The focus of control for day-to-day decision-making and problem-solving shifts from the leader to members of the group. The leader's role is to provide recognition and to listen actively and facilitate problem-solving and decision-making on the part of the staff. This is appropriate where staff have the ability and knowledge to do the task.

d) **Low supportive/low directive leader behaviour (S4)**

This is referred to as the ***delegating style of leadership***. The leader discusses the problems with members of the group until a joint agreement is achieved on the problem and ways to resolve it. Thereafter, the decision-making process is delegated totally. The group then has significant control on deciding how tasks are to be accomplished.

These four basic leadership styles are therefore characterized by varying degrees of directive and supportive behaviour. There is no ***"best leadership style".*** Successful leaders are able to adapt their styles to fit the requirements of the team and the situation. However they may be using one style more often than others.

Development of teams with leadership

The style of leadership could be influenced by various factors such as timeframes, job and task demands, working environment, teamwork, and the skills and expectations of team members. The amount of direction or support that a leader will provide depends on the development level of the team for a specific task, function or objective that the leader is attempting to accomplish. Since the developmental level is task-specific, it is possible to assess the team according to the three key elements - competence, commitment and teamwork, for a specific task. Most of it depends on Competence Commitment and team work.

- **Competence** is a combination of knowledge and skills that can be gained from education training, and/or experience.

- **Commitment** is a combination of confidence and motivation. Confidence is a measure of a person's self-assuredness - a feeling of being able to do a task well without much supervision, while motivation will influence a person's interest and enthusiasm in doing it.

- **Teamwork** is reflected in the level of unity, ability to confront problems and collaboration existing within the group.

An assessment frame work is given below

Table 4: *List of sample criteria*

Competence	Commitment	Teamwork
Qualifications	Hardworking	Respect each other
Knowledge	Enthusiasm	Respect each other's roles
Proven skills	Motivation	Respect competence
Training	Punctuality	Good interaction
Experience	Loyalty	Share responsibilities and duties
Accuracy, speed	Confidence, leading to accepting challenging goals	Ready to share resources
Proven performance	Job satisfaction	Sense of ownership / belonging
Proper placement	Go beyond what is expected	Transparency
Need minimal support	Willing to overcome difficulties	Ability to resolve conflicts
Need minimal supervision	Turns in quality work always	Feel free to seek help from others

Source: Leadership and Strategic Management for TB Managers, Module-3, WHOSEARO-2008.

Effective Management of Leadership styles

Competence, commitment and teamwork can be developed by appropriate inputs. As a leader of the team, it becomes the responsibility to develop the team. The following are suggestions of what you may do to develop or strengthen your team's competence, commitment or teamwork.

Building Competency

- Provide information relevant to roles and tasks.
- Build skills to perform the tasks effectively.
- Sustain and upgrade competencies through long-term training strategies.

Building Commitment – helping individuals realize the potential of their development

- Help individual members to set realistic and challenging goals.
- Support them to achieve this.
- Recognize their achievements through two-way feedback and rewards.
- Give them a sense of belonging.
- Motivate them to take ownership of the programme.

Team building

- Make teams responsible for various tasks.
- Allocate resources to them.
- Recognize the importance of teamwork through team rewards.
- Assign a high value to teamwork in performance appraisal systems.
- Design ways to reduce conflicts and increase collaboration.

Some suggestions:

- Become aware of your lack of flexibility in specific styles.
- Work in collaboration with your colleagues who have more flexibility in that style. Ask them to work with you to manage the situation and learn from them.
- Make special efforts to use that style and you may find that after a while your flexibility in that style increases.
- Assess carefully whether most members of your team know the area of their assignment and how well they know what is to be done.
- Do they have relevant skills and knowledge?
- Are they willing to take responsibility?
- Assess their level of synergy - do they work as a cohesive team, confronting and solving problems, and supporting each other?

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14. How to promote, communicate and advocate for health? [1]

The most important challenge for communication in Public Health Management is:

- To inform the community and new partners
- To change knowledge, attitude and practices and
- To build skill, confidence, capacity and trust.

This process is called by different names in different programmes; Health education programme; Information campaign; Awareness building initiatives; IEC activities (Information, Education and Communication) and now more commonly also health promotion and advocacy for health.

What is communication?

In a simple language, communication is explained as a process of transferring message from the sender to the receiver through a certain channel. Basically, the sender has to express idea or thought in the form of symbol(s) such as language or picture or sound or anything that could be transferred through communication channel. The process of putting thought into symbol is called "encoding". The set of symbol(s) that is transmitted by the sender is called "message". The receiver will receive the symbol(s) or message(s) and will assign meaning to the symbol(s) sent by the sender. The process of assigning meaning to the symbol is called "decoding". The receiver will make response(s) to the message(s), a set of reactions that the receiver has, after being exposed to the message(s). The receiver may give a "feedback", a part of the receiver's response(s) that the receiver communicates back to the sender. Many times, there are found unplanned distortion during communication process, resulting in the receiver receiving a different message from that the sender intended. This is called "noise". Therefore, a communication to be successful should be really planned.

Why communication is needed for individual /community change?

Communication in the context of health is not only sharing new knowledge but carried out with the planned intention of changing attitudes and habits or practices of people in the community to more health promotive as well as the people involved in the programme, health providers and other stakeholders. The communication in in the context of the role of the Health is intended to motivate the people and community respond with positive behaviour changes, in line with expected roles, tasks, activities, behaviours, habits in the prevention and control ill heath and promote healthy life styles and environment in their own community.

Change at individual/community level is not a simple process. Obtaining new positive knowledge does not guarantee individual to obtain new positive attitudes.

Many other factors influence individual to change attitudes, such as value system in the society. Having positive attitudes does not also guarantee individual to practice positive behaviour. Other factors, such as non availability of facility, may hamper to practice new behaviour.

If community has to be encouraged and involved in home and community level health actions and participate actively in community initiatives, then communication activities must form the core of all *District Level Public Health Management* efforts.

What are communication channels?

There are two major channels of communication viz., mass media and interpersonal communication. Mass media communication will consist of different types of information materials used to reach messages to a community such as:

- Posters and charts
- Hand bills or handouts
- Flash cards and flipcharts
- Booklets and pamphlets
- Video cassettes
- Audio cassettes
- Radio and television programmes
- Educational films
- Newspapers, magazines and local media.

Interpersonal communication consists of face-to-face communication with individuals and groups. Interactive communication in groups will also need to be evolved and utilized in the process. These could be:

- Role plays
- Street theatres
- Folk songs / folk media
- Exhibitions
- Puppet shows
- Village events like fairs / festivals events

Principles of communication

Whether mass media information materials are used or interactive communication methods are utilized some general principles for health communications must always be kept in mind. These include:

a. Communication should be a two-way process between communicator and target group
b. Language should be simple, in local vernacular (mother tongue); jargon free; and with colloquial expressions and usage's
c. Local events, positive beliefs and lives of well-known people should be used in communication. Local cultural / folk stories can be adapted and used.
d. Communicators should be encouraged to listen to what the community says, feels or does before planning messages.
e. Communication must be focussed on all the four phases of awareness knowledge, attitude and practices.
f. It should be learner or audience oriented not teacher or communicator oriented
g. Role-plays and real life situations should be utilized as far as possible to help people understand how they can change in the way they do things.
h. While communication is a significant skill, it can be taught to health workers and community volunteers by those who have done it themselves.
i. Planning communication must focus not only on content but also on the process of interactive and participatory methodology.
j. Innovative methods of communication need to be evolved and experimented with all the time. Some recent examples are :
    - Colouring books or sheets on health for little children.
    - Educational toys and models around the theme of health..
    - Activity modules for science experiments and science through interactive activity.
    - Adaptation of folk media and folk arts to spread health messages.

Where communication can help ?

Communicationsfor District Level Public Health Managers should explore all the above methods and approaches and build on the principles outlined. Content must be based on the need of the target audiences/populations and relate to the strategic steps being taken/implemented.

- Health promotion: what can people, volunteers, local health workers do for all the above.
- Early diagnosis and management at home and community level and at health centre: what can people, volunteers, local health workers do for all the above
- Early referrals of severe and complicated cases: what can people, volunteers, local health workers do for all the above
- What communication can be done to support the following and how:
  – A community programme;
  – School health initiatives;

– Community campaigns;
– home based health action

Note :The emphasis in all communication must always be that health action is a responsibility for every person and that the availability of health care services is also everyone's right.
– How can every member of the community develop this responsibility?
– How can every member be empowered to assert this right?

How to evolve an effective IEC programme?

The main steps to evolve an effective communication (IEC) programme for behaviour change in a community are as follows:

- Learn about the existing knowledge, beliefs and behaviour of groups in the community.
- Find out more about all the sources of information on health for the community groups in your district, which are the sources they believe in most? Or who influences them most.
- Review all the communication channels, media and methods and decide on which are the most useful or capable of reaching all the community groups.
- Identify whom in the community you wish to reach and with what specific or general messages.
- Define clearly what ideas you are trying to promote or what actions you want people to take in the community.
- Design your messages building on knowledge and beliefs that are supportive to all health related initiatives and programmes.

Some methods / media may be better for some community groups Interactive channels
Doctors, nurses, community health workers and volunteers, women and youth organizations, religious and community leaders, school teachers and school children, development workers, union leaders, NGO's government staff and civic society organizations.
Mass media
Local newspapers, magazines, radio, television
Small media
Posters, charts, booklets, pamphlets, flashcards, flip charts, videos, audio cassettes, small displays and exhibitions
Traditional folk media
Puppet shows, dramas, street theatre, songs, folk story telling sessions, and folk dances.

a) Decide on content of the messages to be used in the programme. These must definitely include:
    I. Information that the community needs but does not have
    II. Actions that the community group may need to take
    III. Suggested ways to overcome obstacles to taking action
b) Create messages for different information channels selected in (3) some may be short messages and slogans. Others may have many messages. This will depend on each channel.
c) Pretest the messages that you select, on small groups to check whether:
    I. They understand the message
    II. Is it culturally acceptable and appropriate
    III. Is it relevant to the community group

    These can be found out by focus group discussions and interviews and the messages can be suitably modified by community feedback.
d) Produce and distribute the materials
    i. Production should as far as possible be local decentralized and low cost.
    ii. Sometimes special skills and equipment may be required.
    iii. These may be identified in the district or elsewhere.
    iv. Requirements should be estimated realistically.
    v. Distribution channels and means should be clearly identified.
e) Coordinate your communication programme and services with different partners to reach as many members of the community as possible.
f) Evaluate the effect of your messages (Also look at the strengths and weaknesses of all the methods and the activities).
g) Repeat and adjust the messages and methods at frequent intervals by active learning from the field and through experimentation.
h) Develop a new schedule, and plan for conducting your communication programmes based on your evaluation (k) and (l).

Refernces :

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15. How to promote and sustain community participation?[1]

Community participation and partnerships

Enabling the active involvement of the community in efforts to tackle the *Health* problem is a cornerstone of the *District level Public Health Management*. Drawing on the Primary Health Care Strategy, (WHO) endorsed at Alma-ata in 1978, the involvement of the community as active participants in the process rather than as passive beneficiaries is an important challenge.

The guidelines that follow are based on certain principles that are crucial to the successful evolution of a partnership with the community. The community and its representatives both formal and informal must be involved in all aspects of the programme from planning, to organization, to monitoring and to evaluation.

The focus of activities should not be just providing packages of services but enabling and empowering the community to participate in decision-making and taking responsibility. The large range of untapped human and material resources in the community must be mobilized.

The *Public Health* programme must not be compartmentalized or selectivised but must become an integral part of all the ongoing health and development programmes.

A major thrust should be to demystify the problem at community level; build confidence, skill and capability at community level to tackle the problem; and help community to identify the programme as their own The process should also be facilitated with a certain humility so that the health team is willing to learn from local experience, wisdom and culture.

New approaches or alternatives can emerge if this 'learning from the people' and 'working with them' rather than 'for them' becomes a team commitment. 'We need not only to persuade the people to accept the professionals wisdom, but also the professional to understand the peoples wisdom'

Partnership with the Community

What is partnership with community?

- It has now been demonstrated, throughout the world that when a community participates effectively in a health programme with full understanding and involvement then the achievements of that health programme are sustainable and long lasting.

- This partnership should include the involvement of the community in all aspects and stages of the programme and in an increasing sense of ownership by them of the programme.
- All members of the primary health care team under the leadership and direction of the district Malaria Programme Manager will build this partnership.

(The community may be of different types: A village, a tribal hamlet; an urban slum; a small township. Within each of these there may be clusters based on class, caste, occupation, ethnicity or other characteristics. Some form of village or community self-government may be available. Partnership with all these groups may have to be evolved gradually in an area or region. The process will differ depending on the levels of cohesion and the types of diversities/ plurality within each community)

How partnership is developed?

The partnership with a community can be evolved through five generic steps:

- Step one: Identifying potential leadership in the community
- Step two: Evolving a local health committee to support *disease/condition* control
- Step three: Sensitizing and empowering the community
- Step four: Building capacity of local community and its volunteers
- Step five: Organising, managing and sustaining the programme.

Step One: Identify potential leadership in the community

Informal discussions should be held with various individuals and groups within the community to identify individuals who form and mould the opinion of the community and undertake leadership role on various occasions. These may include one or more of the following:

- Leaders – both elected and traditional
- Leaders of community clubs and organizations of farmers, women and youth.
- Religious and socio-cultural group leaders.
- Teachers
- Retired defense services or government personnel living in the area.
- Village health workers and development workers, who stay in the area.
- Informal opinion leaders.
- Others in the community who could assume leadership roles.

Step Two: Evolve a health committee

Organize a committee at the community level with involvement of the potential leaders and orient the committee to the local *Health* situation and the potential malaria control activities to get their help in sensitizing the community. This can be done through one or two informal discussions and dialogue. A "mini

workshop" may be conducted to stimulate action and create commitment of committee members.

Caution

- Ensure adequate representation of women, youth and socioeconomically-marginalised sections on these committee.
- If there was already a health committee in the community earlier then revive it . If there is no committee than start a committee that will tackle all health problems gradually.

The functions of the committee will be:

a) Organize meetings to sensitize the community
b) Help to identify and mobilize community volunteers
c) Plan the local community based activities for Health /
d) Monitor the local community based activities.

Step Three: Sensitizing and empowering the community

(1) With the help of the committee conduct community level meetings to sensitize the community to all aspects of *health* situation.
These meetings should stress at least three things:

a) Create awareness of health situation and programme at village/ community level
b) Emphasize and define community's role in the programme by stressing
   a. That they are partners not only passive beneficiaries.
   b. That their active participation to tackle the problem will ensure benefits to the community.
c) Invite some of them to take active role to control health problems in their villages as active local volunteers who can be trained for specific roles and functions (see Step Four).

(2) The health team members and volunteers may conduct simple surveys in the community to assess the existing knowledge of Health in the community; to understand what the people do when they face health problems (attitudes and local health practices); and then develop a plan of action that will be done by volunteer individually or jointly by community leaders, by each household or joint work by all people in the village. The action plan should build local strengths such as positive beliefs and positive health practices and should counter weaknesses those non-conducive beliefs and health practices.

(3) The community should be empowered through active interaction with the local committee members to develop action plan to prevent and control local health problems in their own village. Several meetings may be conducted for the community to:

a) Understand the local situation
b) To identify the existing resources in the community including people to volunteer and provide material and other resources.
c) To identify the external resources that can be mobilized from the programme especially the health team at district level.

d) To develop a local plan of action that will include:
   - Health awareness building activities
   - Promotion of early diagnosis and treatment
   - Measures for prompt referral when required
   - Prevention activities at individual household and community level
   - Activities that be done by volunteers

e) To develop a simple programme for implementation and for regular monitoring of the programme so that problems identified can be solved and the local experiences will improve the programme and evolve further plans.

Step Four: Building capacity of local community volunteers

The local community based volunteers identified by the committee should be trained to build their capacity to participate effectively in the programme. This training should include:

(1) Knowledge of all the essential aspects of *Health and disease*
(2) How to conduct " simple-surveys" in the community?
(3) Practical skill development to do some or all of these potential functions:
   (a) Make local community members aware of all aspects of specific disease/ health situations and the programme.
   (b) Identify a case of specific disease/ health situations at community level.
   (c) Take appropriate diagnostic procedures made available for disease conditions Eg; blood smear for Malaria
   (d) Treat uncomplicated cases locally
   (e) Identify problem or serious cases and arrange suitable referrals.
   (f) Some form of simple community surveillance .
   (g) Promoting preventive measures at individual and at community level.
   (h) Mobilizing community to support control activities at community level
   (i) Helping to 'monitor and evaluate' programme at community level by facilitating community feedback.

The types of skill taught to local community volunteers will differ in different countries of the region and in different states of the same country since the levels of health care services are varied and the components of the malaria control programmes will be varied. However practical skill development will be the key to success in the programme.

Step Five: Organizing, managing and sustaining the programmes

Once the plans of the local health programme is drawn up by the District Level Public Health Managers by interactive dialogue with the local health committee and the local volunteers are trained then the programme must be organized and managed in close collaboration with the local committee and the volunteers. As part of the partnership with the community, the programme will consist of the following major components:

(1) Empowerment of women in the community endorsing their role as the main health care providers at family level

(2) Organizing diagnosis, treatment and referral at community level
(3) Organizing control at community level
(4) Sustaining the community level action and partnership which includes community based surveillance, monitoring and evaluation

As the programme evolves and all the above components are organized and managed, then through a continuous interactions with the committee and the volunteers and members of the community, the programme managers can seek feedback and suggestions for modifying and improving the programme.

This can feed into the planning cycle for the programme so that newer and newer ideas, innovations and changes take place in the health programme and the community partnerships.

The above section has outlined the importance and methodology for community participation and involvement, which is a core principle of primary health care and district health management today. Two important additional components of this involvement especially in the context of current health challenges need to be kept in mind. The first is the need to specially empower women who in all societies -both traditional and modern – in rural and urban, continue to be the key health action initiators, and the second is to involve community in health action at collective and community level going beyond the orthodox bio medical focus on individuals and families. The next two subsections focus on these components.

Empowerment of Women

An important challenge for the District level Public Health initiative in each country is the recognition and involvement of women in the programme as health care partners.

Why empowerment of women?

- Women have been traditionally the main health care providers at family level and community level. They take family responsibilities that include nutrition, care of the children, care of the sick and elderly. This has provided them more knowledge, and skills to undertake health care tasks.
- In many parts of the world, women have shown greater potential and ability, collectively to promote and sustain programmes especially related to health. They support each other effectively

In many societies and communities women already face the triple burden of family, work and childcare. It is therefore necessary to involve them in health programs, recognizing their potential and their status but not necessarily adding to their burdens.

Empowerment of women must be closely complemented by the involvement of men to share the responsibilities of health at both family and community level.

Greater involvement of women through an active empowerment process is therefore an important step. Women can be empowered in, community and family-based actions.

What can empowerment of women do?

Women can be empowered to play a variety of roles that are required for effective community and family-based control of health problems These are:

(1) Primary health care/ management of health problems at family level
(2) Identification of family members that need referral
(3) Health education and awareness building about common health problems and their management with locally available resources.
(4) Management of cleanliness in and around the house.
(5) Use of preventive measures at home level.
(6) Special needs of women who are pregnant and very small children when they fall ill.
(7) Involvement in organizing / managing health programmes as community volunteers.
(8) Involvement in organizing / managing health programmes as members of women's organizations or community health committees.

For all these roles they need empowerment training that provides them knowledge and skills to play their roles and also knowledge and awareness about existing health care structures and alternatives.

How to achieve women empowerment?

- Women should be reached preferably in groups to help the interactive and participatory process between and among them.
- They can be reached at and or through:
  a) Women's organizations or clubs (e.g. Mahila mandals)
  b) Informal community level groups of women
  c) Religious and social organizations and gathering
  d) Weekly community markets
  e) Voluntary organizations working with and for women
- Special groups of women who are already playing leadership or other roles in society can be involved to take greater interest in mobilizing and empowering other women in the community. These may be :
  – Women members of local bodies/village self government
  – Women teachers
  – Women staff of banks, post offices and other services.

– Women health and development workers.

- All the members of the above groups can be trained in the functions listed above through regular local training sessions that use effective IEC materials.
- A home care package that is particularly focused on women volunteers and participants should be stressed.

Women involved in social development work should be recognized and honoured. This would act as an incentive for involvement of more women.

Health action at Community Level

There are ways by which people in the community can protect themselves from common illnesses and prevent some of them.

(1) Avoiding disease though personal protection
(2) Controlling the disease spread by elimination/ taking precaution towards the disease causing factors in and around the house and in the community.
(3) provision of adequate knowledge and skill to health workers to take care of disease at a primary level
(4) For disease prevention to be effective at household and community level, the local health committee, community volunteers, other members of the community, particularly women should be made aware of all the simple and effective methods to prevent and control disease.

Why prevention is necessary?

- Remember prevention is better than cure because prevention is simple and low cost.
- Diseased conditions also lead to increased stress and irritability.
- Teaching the community to take measures to prevent disease has additional advantages of teaching people to take more personal responsibility for their own health as well as encouraging collective action to tackle some of the health problems at the community level.

How to promote community action?

- Identify the target community; rural, urban and developments project area, (stratify if there are diversities in the socio-epidemiological situation of heallth in the area).
- Motivate the community through awareness campaign using appropriate IEC materials.
- Establish a committee with a chairperson. Active members such as teachers, women postmasters, retired employees, development workers, religious leaders can be included with one person assuming the leadership role.
- The activities of the committee should include
    - Motivation of the community through interactive meetings
    - Identifying solutions - including those from community experience

    - Planning the campaign
    - Monitoring and reviewing the campaign.
- Small groups with active members can be formed to generate collective force in taking health initiatives.
- School children and youth can be motivated in planning health campaigns and improving the environment .
- Technical skills in improving environmental sanitation need to be developed so as to make the community self-reliant.
- Potential avenues can be explored for resource mobilization from local sources and from other sectors and departments to enhance the campaign nature of activity.
- If the campaign has to be successful then all sections of the community should be involved - children, youth, women, teachers, others. The campaign committee should identify the roles of each of these groups and orient them to those roles to ensure that the campaign goes smoothly.
- Other departments who can help the campaign are:
    - Local administration
    - Sanitation / water supply
    - Agriculture department
    - Fisheries
    - Public works department
    - Forestry etc.

Cooperation and resources from all of them especially their field workers should be mobilized.

Sustaining community level action and partnership

Sustaining Community Level Action and Partnership to eliminate health problem in the community, action at community level should be sustained on a long term basis.

Community participation can be sustained by the following measures in the programme:

Involve community right from planning in all stages of programme.

(1) Frequent interaction with community, providing solutions to the problems in carrying out health programmes will also sustain the interest of community.
(2) Promote socially acceptable and viable solutions that are
    - Culturally acceptable
    - Low – cost, available / affordable by all
    - Socio-epidemiologically sound and need based.
(3) Ensure that supplies are constantly available This will also greatly help the sustainability of the programme.
(4) Develop dynamic leadership and encourage self reliance.

(5) Minimize conflicts by keeping organizations small; restricting memberships to persons with harmonious objectives; defining objectives; in a focussed way and distributing benefits equally.
(6) Increase popular awareness of the value and the benefits of a malaria programme.
(7) Encouragement of income generating activities, e.g., social forestry plantations will also help sustainability of the community involvement.
(8) Provide some incentives for the community from the district administration in the form of
- Declaring healthy villages
- Developmental inputs.

Refrences :

1. WHO -SEARO, *Guidelines for implementation of Roll Back Malaria at district level,* SEA MAL-230 Draft, World Health Organization- Regional office for South East Asia, 2003

Further Reading on community participation

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16. How to build and sustain other partnerships?[1&2]

General principles: *This chapter shares out the concept of partnership and its general principles.* Partnership building is a major challenge for *strengthening the public health systems and its management.* There is need to build partnerships, within and outside the health sector for outreach of health as a collective responsibility.

What does that mean? Who decides the partners? What is the force, which binds partnerships? These are some of the questions which this section will try to address.

Partnerships are built on

- Common interest;
- Mutual respect;
- Clear manageable common objectives;
- Commitment to contribute time, resources, energy and
- Mutual trust.

Partnerships should lead to:

- Significant social gains or reduction in the problems which the partnership seeks to tackle;
- Common goals, more productivity and welfare of the people;
- Strengthening of the programmes role as a catalyst for health sector
- Development and the efforts involved in establishing and maintaining the partnership should be worth it.

The concept of Partnership: Partnerships are alliances in which individuals, groups or organizations agree to,

- work together to fulfil an obligation;
- undertake a specific task;
- meet a common goal;
- share the risks as well as the benefits;
- review the relationship regularly and
- revise the agreements as necessary.

How to Build Partnerships?

The partnership should be built gradually through the following steps.

(a) **<u>Identify all potential partners in the district</u>**

- List out all government and non-government health care providers and institutions including civil society and private sector providers and all those from other sectors whose activities can support health programs or present challenges to them.

- Identify all those who are likely to be potential partners in the health programmes giving priority to those who are already doing some activities, that can be supportive of the health programmes.

(b) Involve in District coordination committee

- Involve some of the key representatives of associations of the health care providers, civil society and the private sector in the local Health committee described later

(c) Sensitize all the potential partners

- Involve all the potential partners by sensitizing them to all aspects of the health programmes of the district through
  – Informal personal interaction
  – Formal meetings
  – Communication handouts and newsletters.
- Those who show specific interest and enthusiasm can be further oriented through workshops and skill orientation sessions.

(d) Identify the role and contributions they could each make to the programmes.

- They could adopt health activities in their own work places.
- They could join health activities at the community level.
- They could participate in IEC campaigns, events, exhibitions and other programmes.

(e) Provide assistance to all the partners

- If these partners require they should be offered technical information and training support to enhance their partnership in the programme.

(f) Monitor and review the private sector partnership

- Each partnership should be reviewed regularly and the representatives of the health care providers,civil society and the private sector in the district coordination committee should participate in the monitoring / review of the control programme at the district level.

Coordination of partnership

The key partnership strategy at the district level is to evolve a health partnership coordination committee at the district level and support the development of local leadership potential through working together.

The health partnership coordination committee at the district level needs the involvement of at least the following:

- The District Administrator

- District Health Officer
- Health Officer designated for different health programmes
- Education Officer
- Agricultural Officer
- Public Works engineer
- Representative leaders of local / village self government
- Selected NGO/ civil society representatives
- Representatives of health care providers associations if any
- Public / private industry if any,
- Officers in charge of:
  - Water and sewerage
  - Irrigation
  - Rural and urban development
  - Social welfare etc

(The composition of this coordination committee will vary in each country and state and will depend on the resource persons available at district level)

Evolving the role of the health partnership coordination committee:

Step One

A coordination committee chaired by the district administrator and health officer as secretary will be the first step to ***develop leadership at the district level***. In keeping with the new philosophy of Health Intervention/ promotion partnerships, representatives of leaders of the community, NGOs and civil society, private practitioners and provider associations should also be included in the committee so that the ownership and the stakes of a much wider group are facilitated.

Step Two

The committee should evolve mechanisms for:

- Promoting participation - meetings, working groups, subcommittees focussed on special ideas.
- Sharing information - communications, newsletters
- Formulating strategic action plans for each department, sector, partner represented on the committee
- Implementation and its monitoring
- Fostering new partnerships - (new partners will keep joining as the programme evolves and spreads)
- Interdepartmental, intersectoral and inter-partner coordination.
- Reviewing partnership through regular monitoring and review

Step Three

Prepare IEC materials applicable for the district to motivate participation by all these sectors. Each member of the committee must be encouraged to plan IEC events in his/her own sector and increase awareness and involvement of the sector

Step Four

Communicate integrated Health Intervention/ promotion plans for the district to various sectors and partners involved in the programme through regular meetings and update.

Step Five

All members of the committee should facilitate the participation of the community as the central theme of the programme. (refer next section) Community mobilization will therefore be a shared responsibility.

Step Six

Constantly review the Health situation and programme with all partners, especially the community.

Developing capacity of leadership

The success of *District management* will rest on the capacity of district level officers placed in charge of the programme to carry out the above steps. For this purpose, they will need training /orientation to develop the following skills:

- Managerial and leadership
- Strategic planning
- Monitoring and evaluation
- Communication
- Networking and partnership
- Advocacy
- Community mobilization
- Resource mobilization
- Rapid appraisal procedures

Suitable resource persons and training centers from governmental and non-governmental sectors should be identified for this capacity building process through regular workshops and skill development sessions.

Partnership with Educational Sector

Why education sector?

Children and youth are a very important group to be reached by IEC and other programmes because:

- They are the future citizens who should be made more aware of health as a responsibility and a right
- They are eager to learn scientific concepts and have great energy and enthusiasm that can be harnessed for field programmes and campaigns
- Elder children and youth can be motivated to get involved in civic society campaigns to sensitize them to civic and social responsibility.

- Children can carry messages home and pass on information to parents and other members of the family including persuading them to change their ideas and attitudes
- The role of children and youth in Health programmes and campaigns are increasingly being recognized all over the world and in the region.

What is the target population?

The partnership with the educational sector should be aimed at the following target population.

- Teachers, principals, and administrators
- School children and college going youth (6-21 year)
- School dropouts
- Children with no formal education
- Child labour and working children

The partnership will therefore focus on all the locals schools – primary middle and high schools; colleges and vocational training centers and polytechnics; non-formal education programmes for school dropouts and working children.

What is expected from children and youth?

- know cause and control of common health problems
- how to change attitudes and practice preventive measures
- involve in health education campaigns to create awareness among community
- participate in preventive measures (in and around educational institution)

What is the role of partners?

- Inclusion of health education in school / college curriculum with a focus on common health problems .
- Motivation of students to participate in health campaigns
- Mobilize their participation in preventing illness and promoting health
- Involve them in community / family awareness programmes.

How to work?

(1) List out all the educational sector institutions in the district, finding out details of the levels the number of children, teachers etc.

(2) Request the Education Department / Directorate to send a circular to all schools / colleges to join the health initiatives in the district, and invite them to attend workshops/meetings.

(3) Invite them to some meetings and workshops to sensitize / orient them to all aspects of common health problems in the area and how children and youth can be involved in them.

(4) Involve the education department in celebrating health events by carrying out health activities on those occasion.

(5) Exposing students and youth to various aspects of health and including health activities and experiments as project work in the curriculum.

(6) Involve science clubs and science networks in increasing awareness about common health problems amongst children and youth.

(7) Involve parents to initiate health promotion and prevention activities in their neighbourhood.
(8) Conduct seminars / guest lectures / demo-exhibitions / field trips / essay competitions / debates appropriate to the level of schooling / education.
(9) Initiating debates / competitions between schools, colleges, and universities on health problems and to create widespread awareness.
(10) Including the practice of health activities by students and youth in scout movements, national defence and social service auxiliary corps.
(11) Explore the possibility of inputs by teachers and students into fairs and festivals.
(12) To support all these activities a small booklet on how children / youth can be involved in health should be prepared supported by posters and charts for wide distribution.

How to sustain the above activities

(1) Regular meetings with teachers and staff involved in education should be held.
(2) Capacity building/training sessions for volunteers, teachers and high school students should be organized.
(3) Organize events at regular intervals to maintain the interest and tempo of awareness activities in the educators and the students / youth. E.g. a *Health Day/ Health action Day; a Health / Health action week or a Health / Health action month.*
(4) Evolve separate Guidelines For Partnership with Agencies Involved In Non-Formal Sector of Education

Intersectoral Collaboration

Why partnership with other sector?

Inter-sectoral coordination is another important challenge in the *Management of Public Health.* Today there is greater knowledge about the development and *health* strategies that can lead *to a better participation* and *these strategies and methods* must be incorporated before starting *public health programmes* and *Interventions*.

Various other departments be it agriculture, industry, forestry, mining, power and irrigation, rural and urban development etc. can become partners in *Public Health Management*

Many departments like Railways, Transport and Communication, Defence, Industry and others look after large sections of the population their own staff and their families. They can take help of the Public Health Programmes for protective/ curative and thus protecting their own work force.

Inter-sectoral coordination therefore aims at involving all other sectors outside the health sector who contribute to the problem and who can also

participate in the solution and the programme. This inter-sectoral partnership/co-ordination is therefore urgent and crucial.

What should be done?

It is important for the programme managers to identify all the sectors in the district who can contribute both to the problem and to the problem solution. The partnership with each of these sectors will seek to:

- Orient them to important aspects of the *Public Health Situation and appropriate strategies for common health problems.*
- Identify ways and means by which their activities may be contributing to the problem/ situation.
- Identify ways and means by which they can contribute to the solutions.
- Evolve *Public Health measures* /strategies at their work places or for the
  populations / workforce they cover.
- Identify skills, capacities and other resources they may have which can be tapped to support the district level health programmes.

How it should be done?

a) Identify all the sectors in the district that need to be involved in an inter-sectoral partnership. Identify their functions and their functionaries at district level.
b) Dialogue with each of these departments / sectors through personal interactions and visits. In these discussions and visits, identify all the activities they can do to support the district health programmes. Also, identify the information they need and the capacities / skills that may need to be developed.
c) Invite them to join the coordination committee and be part of the planning and strategy development process for the district.
d) Through regular meetings, the partnerships can be evolved and operationalized.
e) Training and or orientation or specific skill training sessions can be provided for staff of these sectors if they are required.
f) Through regular meetings monitor and evaluate these programmes and constantly renew, adapt and make the partnership more effective.

[Different types of sectors will participate in different ways. District level partnerships should be evolved with each of them gradually.]

Partnership With Civil Society (Non-Governmental organizations and voluntary agencies)

The role of civil society especially the voluntary agencies (not for profit NGOs) is being increasingly recognized in planning and policy circles as an effective complementary/ supplementary strategy in health care programmes.

In the past, they have played this role without much governmental support. In recent years, a greater degree of collaborative effort is emerging as a policy alternative.

Why develop partnership with Civil Society?

Civil Society organisations have the following strengths :

a. They are closer to the people and usually more aware of grass root realities.
b. They have experience to work with more marginalised groups, the underprivileged and difficult to reach areas
c. They are committed to certain values and principles.
d. They often have a stronger development orientation and awareness building commitment and skill.
e. This flexibility is a strength.

Civil Society organisation have often the following weaknesses:

a. They are individualistic and not often linked by any integrated network.
b. They are inadequately aware of governmental programmes.
c. They have their own programmes and agenda.
d. They are very diverse in their, ideology, type, size, distribution, linkages and competence.
e. They lack adequate professional expertise, being stronger in motivation rather than in skills.
f. They often follow fund driven or donor driven agendas.

It is a very important development that collaboration of government and civil society are being increasingly promoted in recent years. District Management for public health should take this new opportunity, as an asset for obtaining more civil society collaboration to reach the unreached population through various areas of collaborations. The evolving process of partnership should build on civil society strengths, and capabilities.

What are the avenues and areas of partnership?

(a) **Building Community awareness**:
Any community awareness programme should be relevant to the local context and hence working with the civil society as partners could greatly enhance the efficacy in the community awareness programmes. Developing IEC material relevant to the local context and carrying health messages through indigenous and local methods will have greater acceptability and adoption and could be a major role for civil society .

(b)**Involvement of community in planning:**
Most civil society organisations promote participatory methods that favours bottom up planning and ownership of the programme by the community. In the area of Public Health Management, this will be a good strategy and the government could use the expertise available within the civil society.

(c) **Community mobilization for community action:**
As mentioned earlier this is one of the great strengths of civil society. A recent example of this has been the role of civil society in the pulse polio programme. Similar strategy could be specifically adopted for Public health Management and Health promotion for other health problems.

(d) **Early Diagnosis and prompt treatment**:
As civil society organisations are the first level contact in the community, access to diagnosis and treatment could be made available nearer to the community. Civil society could be involved in case finding, fever treatment centres and stocking medicine and health education materials.

(e) **Epidemic preparedness:**
A few civil society organisations could be built as resource centres for epidemic preparedness. They could be trained in surveillance and monitoring the common health problems and initiating a response when these problems begin to increase.

(f) **Building *Health* profile in area:**
Civil society organisations could help in building a profile (socio-epidemiological) of h*ealth problems* in the area using interactive participatory approaches and appraisal methods. These would help to understand community behavioural pattern and health seeking behaviour, which could be useful for effective strategy formulation.

How to build up partnership with Civil Society ?

The Partnership with civil society could be gradually built up by the following steps:

(a) Identification of civil society organisation in the districts; The District coordination committee will develop simple tools to identify CSO's and their existing activities.
(b) Setting up district coordination committee; Include the potential CSO in the coordination committee.

(c) Define lead role that CSO's can take in *District level public health action*.
(d) Sensitization and capacity building of the CSOs; The committee will conduct a workshop for the identified CSOs to sensitize them on the issues of *public health* and do a need assessment to look at gaps in the skills. This

committee will also identify resource persons in the district to build the skills of the CSOs,

(e) Information dissemination through the CSO's; Involve CSOs in development of appropriate information and programme guidelines for various activities for the CSO partners on the health issues identified. This in turn will be further simplified by the CSOs for community level dissemination. Information from the community also will be received, sometimes through the CSO at the district level for follow-up. This may be documented systematically or could be taken up for policy advocacy work.

(f) District level action plan; As member of the committee, CSOs are involved in development of action plan. These will include targeted intervention and preparation, development and distribution of IEC material. The district coordination committee will ensure that each district or even sub-district has an action plan worked with the help of CSO partners. This may be presented to the committee and queries clarified and approved. As decentralized local strategies based on local health situation will be the most effective strategy.

(g) Participatory planning and monitoring; The CSOs will be encouraged to use participatory tools for programme planning and monitoring. Other than this, they will also develop indicators as MIS for bringing out reports and to measure outputs.

(h) Monitoring and review; the committee along with the partner CSO's and community will conduct this review at regular intervals to give direction to the programme.

(i) Documentation; enhancing the documentation skills of CSOs involved in the programme are an important adjunct activity and should be promoted. Learning from field experiences both positive and negative are an important adjunct to group learning and CSOs and the government health team should be encouraged to do so, constantly.

Advocacy; CSOs could be strong advocates. Many health programmes have been closely collaborating with CSOs to advocate with political leaders, local leaders and public to obtain attention and support. The committee along with the partners, and CSO networks will take up local issues for advocacy. This may be at the local government level or at the district level.

Partnership with Private Sector

The Private Sector include the following at the District level Health care providers

- General private practitioners of all systems of medicine
- Private dispensaries, health centres, nursing homes, hospitals
- Laboratories and diagnostic centres
- Chemists and pharmacists

Non-health private sector Which includes

- Local industries
- Small-scale industries

- Construction companies and contractors
- Engineering firms and
- Other private companies.

Why private sector? because...

- The public health sector and government programme cannot reach all the people or make all the health gains on its own.
- The private sector already runs a large number of health related services that reach a large number of the population.
- The private sector has management, marketing, organizational and communication skills that can be harnessed to enhance a government programme.
- There are financial resources from the private sector that can be harnessed to support government programmes as their social/community responsibility.
- In some cases like very large corporate sector establishments or private industrial establishments they may provide townships for their own workers and their involvement to ensure that these townships do not allow unhealthy conditions to develop due to poor environmental management is necessary.

The partnership with the private/corporate sector should be evolved very carefully since the profit motives of private sector are strong and the government health programme must not become:

- a vehicle to sell specific goods or services or
- become compromised in any way due to financial support and any unhealthy practices related to their deployment.

To avoid conflicts of interest whether real or perceived – the concerned government programme while evolving the partnership must establish procedures that will ensure:

- **Final normative decisions are free from undue influence.**
- **Industry funding is not used for salaries of staff involved in normative decisions.**
- **Consultations and other normative activities never have their majority financing from the concerned industry.**

(Source: Partnerships for Health Promotion)

What are private sector partnerships?

While the partnerships should gradually explore all sectors of the private sector – each group must be involved in those aspects of the programme in which they have specific expertise interest and skill.

(a) Health care providers

- All health care providers at the health facilities level should provide scientific diagnosis and rational treatment of cases under their care.
- All of them should be made aware of the situation in the district and how to identify severe or complicated cases that need referral to centres that are equipped to handle these complications.
- All the health care providers at different levels of facilities should be involved in health education and IEC activities that provide all the information to patients and the communities from which the patients come simple knowledge about the do's and don'ts for, prevention, treatment and control.
- All of them should be encouraged to notify the health authorities about cases they diagnose or treat so that suitable public health measures can be taken including enhancing epidemic preparedness and response.

(b) Non – Health private / industrial sector

They could be involved at district level to provide the following supportive services to the programme.

- Financial resources for the programme
- Promotion and distribution skills
- Supporting IEC activities.
- Taking steps to provide healthy work place conditions in their institutional environs.

How to build partnership?

The partnership should be built gradually through the following steps.

(1)Identify all potential partners in this sector in the district

- List out all the potential private sector partners including practioners and instituions in the district.

- Identify all those who are likely to be partners in the health programmes giving priority to those who are already doing some activities, that can be supportive of the programme.

(2)Involve in District coordination committee

- Involve some of the key representatives of associations of the health care providers and the private sector in the local Health coordination committee described earlier.

(3)Sensitize all the potential partners

- Involve all the potential partners by sensitizing them to all aspects of the health programmes in the district through
  - Informal personal interaction
  - Formal meetings
  - Communication

- Handouts and news letters.

- Those who show specific interest and enthusiasm can be further oriented /trained through workshops and skill orientation sessions.

(4) **Identify the role and contributions they could each make to the programmes.**

- They could adopt health activities in their own work places.
- They could join health activities at the community level.
- They could participate in IEC campaigns, events, exhibitions and programmes.

(5) Provide assistance to all the partners

- If these partners require they should be offered technical information and training support to enhance their partnership in the programme.

(6) Monitor and review the private sector partnership

- Each partnership should be reviewed regularly and the representatives of the health care providers and the private sector in them district coordination committee should participate in the monitoring /review of the control programme at the district level.

Private practitioners and District Public Health Management – A special challenge

In many South Asian countries the treatment of common diseases and health problems has become quite irrational.

- A wide variety of irrational combinations and regimes often at high cost are prescribed for patients suspected to have common problems
- The illness episode is often exploited by the use of injectable preparations and other adjuncts not in consonance with rational care guidelines.

- The standards of clinical diagnostic facilities are falling and very often practitioners prefer symptomatic treatment rather than sending for a confirmatory laboratory diagnosis.
- Quality of medicines is variable.
- Quality controls and checks are poor in laboratory facilities and drug procurement systems.
- Some degree of medical misinformation also prevails due to medical representatives from some companies making unscientific claims about the superiority of their products over others available in the market particularly generic drugs in the government programmes.

Irrational medical practice is therefore a major problem, which should be urgently tackled.

How to tackle irrational medical prescription ?

(1) Regular continuing Medical Education sessions on Rational care in consonance with national Treatment guidelines. These can be organized by :

- The District Level Public Health manager (district level)
- Local professional associations
- Local medical colleges and other health training institutions.

(2) Rational treatment guidelines should be prepared as pamphlets, booklets, charts, calendars or handouts and widely distributed to all the practitioners and pharmacists in the District.

(3) All practitioners should be encouraged to notify cases of which they diagnose and treat, to the district or sub-district level health authorities so that suitable follow up measures can be taken by the manager and his team.

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Further Reading on partnerships

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